

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07615

Reg. Dist. No. 300

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural</b> c. LENGTH OF STAY IN 1b <b>15 min</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Potomac River- Shepherdstown Bridge</b>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> d. STREET ADDRESS <b>218 Summit Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Ward</b> Middle <b>Wilson</b> Last <b>Abshire</b>		4. DATE OF DEATH Month <b>July</b> Day <b>1</b> Year <b>19 56</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 17, 1926</b>
9. AGE (In years last birthday) <b>30 yrs.</b>		IF UNDER 1 YEAR Months <b>30</b> Days <b>30</b>	IF UNDER 24 HRS. Hours <b>30</b> Min. <b>30</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Production</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Aircraft</b>	
11. BIRTHPLACE (State or foreign country) <b>Gerrardstown W. Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Carl R. Abshire</b>		14. MOTHER'S MAIDEN NAME <b>Effie L. Gano</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> <b>Korean</b>		16. SOCIAL SECURITY NO. <b></b>	
17. INFORMANT <b>Mrs. Effie L. Abshire</b>		Address <b>Hagerstown Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>929.8</b> DUE TO <b>Suffocation by drowning</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b></b> DUE TO (c) <b></b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b> INTERVAL BETWEEN ONSET AND DEATH <b></b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Drowned while trying to rescue another swimmer</b>	
20c. TIME OF INJURY Month, Day, Year <b>7-1-56 1956</b> Hour <b>4:15</b> m. <b>pm</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>River</b>	20f. (City or town) <b>Sharpsburg</b> (County) <b>Wash</b> (State) <b>Md</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>S. Robert Wells</b>		DATE SIGNED <b>7-2-56</b>	
EXAMINER'S NAME (Type) <b>S. Robert Wells, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>7-3-56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son</b>		ADDRESS <b>Hagerstown Md.</b>	
24a. REC'D BY REGISTRAR <b>July 6 1956</b>		24b. REGISTRAR'S SIGNATURE <b>E. G. Berger</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF NEW YORK  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Race		Date of Death		Place of Death	
John Doe		Male		35		White		1956		New York	
Cause of Death		Manner of Death		Occupation		Education		Marital Status		Previous Illnesses	
Heart Disease		Natural		Teacher		High School		Married		None	
Signature of Medical Examiner		Signature of Coroner		Signature of Registrar		Signature of Witness		Signature of Witness		Signature of Witness	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. 1

JUL 11 1956

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07616

7638

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Pa.</u> b. COUNTY <u>Franklin</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shady Grove</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASHINGTON COUNTY HOSP</u>		d. STREET ADDRESS <u>75x-3</u>	
3. NAME OF DECEASED (Type or print) <u>Jane Aliene Alexander</u>		4. DATE OF DEATH <u>July 19 1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>wh</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/19/56</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Washington Co. Hospital</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Gordon Lee Alexander</u>		14. MOTHER'S MAIDEN NAME <u>Thelma Jean Leister</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Thelma Jean Leister Alexander</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subarachnoid Hemorrhage</u> DUE TO <u>760.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Tumorous tear</u> DUE TO (c) <u>Cholesterosis</u>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>10 min.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>19 July 1956</u> to <u>19 July 1956</u> , that I last saw the deceased alive on <u>19 July 1956</u> , and that death occurred at <u>9:00 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Gamerbach</u> M.D. <u>Williamport, Md</u>		DATE SIGNED <u>50 July 56</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7/20/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Green Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Waynesboro, Franklin Pa.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Z. Groves</u>		24a. REC'D BY REGISTRAR <u>Walter Z. Groves</u> DATE <u>7/20/56</u>	
		24b. REGISTRAR'S SIGNATURE <u>Walter Z. Groves</u>	

## MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

1956 76 701

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07617

7639

## CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>WASHINGTON COUNTY HOSP</b>				d. STREET ADDRESS <b>35 N. FOUNDRY STREET</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>Baby Boy BAKER</b>				4. DATE OF DEATH <b>JULY 19 1956</b>			
5. SEX <b>Male</b>		6. COLOR OF RACE <b>Wh.</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JULY 19. 1956</b>	
9. AGE (In years lost birthday) <b>2</b> yrs.		IF UNDER 1 YEAR <b>3</b> Months <b>3</b> Days <b>37</b> Hours <b>37</b> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <b>Calvin Elmer Baker</b>				14. MOTHER'S MAIDEN NAME <b>Ella Grace Ross</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <b>MOTHER</b>				Address <b>35 N. Foundry St. Hagerstown Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ATELECTASIS</b> <b>762.5</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>PREMATURITY (5 1/2 mo. pregnancy)</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>3 hrs</b> <b>3 hrs</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <b>19</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Paul Harrison MD</b>				ADDRESS (Street, city or town, state) <b>318 N. Potomac Hagerstown MD</b>			
PHYSICIAN'S NAME (Type) <b>Paul Harrison</b>				DATE SIGNED <b>7/20/56</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>7/23/1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>ROSE HILL</b>		22d. LOCATION (City, town, or county) (State) <b>HAGERSTOWN MARYLAND</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>SUPER-POLICE FUNERAL HOME</b>				ADDRESS <b>HAGERSTOWN MD.</b>			
24a. REC'D BY REGISTRAR <b>July 23 1956</b>				24b. REGISTRAR'S SIGNATURE <b>Phasht Bowers</b>			

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7640

## CERTIFICATE OF DEATH

07618

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington Co. Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Dora</b> Middle <b>Baker</b> Last <b>Baker</b>				4. DATE OF DEATH Month <b>7</b> Day <b>8</b> Year <b>19 56</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 8, 1884</b>	
9. AGE (In years last birthday) <b>72</b> yrs.		IF UNDER 1 YEAR Months <b>72</b> Days <b>72</b> Hours <b>72</b> Min. <b>72</b>		IF UNDER 24 HRS. Months <b>72</b> Days <b>72</b> Hours <b>72</b> Min. <b>72</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>home</b>		11. BIRTHPLACE (State or foreign country) <b>Washington Co. Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Frisby Mongan</b>				14. MOTHER'S MAIDEN NAME <b>Sally Moats</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT Address <b>Mr. Welty Baker Jr. Hagerstown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonitis</b> 492X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arterio Sclerotic Heart Disease</b> INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19							
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>7/5, 1956</b> to <b>7/8, 1956</b> , that I last saw the deceased alive on <b>7/8, 1956</b> , and that death occurred at <b>4:30 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>444 Summit Ave, Hagerstown Md</b> DATE SIGNED <b>7/8/56</b>							
ACTUAL SIGNATURE <b>O. H. Binkley</b> M.D.							
PHYSICIAN'S NAME (Type) <b>O. H. BINKLEY</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>7-11-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Manor</b>		22d. LOCATION (City, town, or county) (State) <b>Tilghmanton Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Fred W. Kraiss Hagerstown, Md.</b>				24. REC'D BY REGISTRAR <b>July 11, 1956</b> 24b. REGISTRAR'S SIGNATURE <b>Wash H Bowers</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7680

## CERTIFICATE OF DEATH

Reg. Dist. No.

07619  
304

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Hancock Md</b>				c. LENGTH OF STAY IN 1b <b>Life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Home</b>				d. STREET ADDRESS <b>Rural Hancock Md.</b>			
3. NAME OF DECEASED (Type or print) First <b>Issac</b> Middle <b>J</b> Last <b>Bishop</b>				4. DATE OF DEATH Month <b>7</b> Day <b>23</b> Year <b>19 56</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6.17.1868</b>		9. AGE (In years last birthday) <b>88</b> yrs.		IF UNDER 1 YEAR Months <b>1</b> Days <b>6</b> Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farming</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		11. BIRTHPLACE (State or foreign country) <b>Fulton County Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Bishop</b>				14. MOTHER'S MAIDEN NAME <b>Caroline Gardner</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs Herman Derrier</b> Address <b>Rural Hancock Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Myocarditis</b> <b>592X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic Nephritis</b> DUE TO (c) <b>Senility</b>						INTERVAL BETWEEN ONSET AND DEATH <b>6 wks</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b></b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>May 10</b> , 19 <b>56</b> , to <b>July 23</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>July 23</b> , 19 <b>56</b> , and that death occurred at <b>1130 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Hancock, Md.</b> DATE SIGNED <b>7/24/56</b> ACTUAL SIGNATURE <b>L.M. Shaffer</b> M.D. <b>L.M. SHAFER M.D. HANCOCK, MD.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7.26.56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>May,s Chapel Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Warfordsburg Fulton Penna.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard F Stone Hancock Md</b>				24a. REC'D BY REGISTRAR DATE <b>7/24/56</b> 24b. REGISTRAR'S SIGNATURE <b>J. H. Keller</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

STATE OF NEW YORK - DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

BUREAU V. 1

JUL 27 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7641

## CERTIFICATE OF DEATH

Reg. Dist. No.

07620  
302

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>PA</u> b. COUNTY <u>FRANKLIN</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>				c. LENGTH OF STAY IN 1b <u>4 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL</u> <u>75x3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASHINGTON COUNTY HOSPITAL</u>				d. STREET ADDRESS <u>CHARMIAN</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MINNIE</u> Middle <u>ELIZABETH</u> Last <u>BLOOM</u>				4. DATE OF DEATH Month <u>JULY</u> Day <u>28</u> Year <u>1956</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>OCT. 7, 1883</u>	
9. AGE (In years last birthday) <u>72</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>FREDERICK, COUNTY, MD.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>CLAYTON SHUFF</u>			
14. MOTHER'S MAIDEN NAME <u>ALICE FOSTER</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>177-46-0101</u>				17. INFORMANT <u>Walter M. Bloom, Frankford Rd. Pa.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>uremia</u> <u>181X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>Advanced carcinoma of</u> DUE TO (c) <u>urinary bladder</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>a. 1.</u> Month <u>19</u> Day <u>19</u> Year <u>1956</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>July 25, 1956</u> to <u>July 28, 1956</u> , that I last saw the deceased alive on <u>July 28, 1956</u> , and that death occurred at <u>6:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Joseph C. Crisp M.D.</u>				ADDRESS (Street, city or town, state) <u>115 King St. Hagerstown</u>			
PHYSICIAN'S NAME (Type) <u>JOSEPH C. CRISP M.D.</u>				DATE SIGNED <u>July 31, 1956</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8/1/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BLUE RIDGE</u>		22d. LOCATION (City, town, or county) (State) <u>THURMONT MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Z. Hare</u>				ADDRESS <u>Hagerstown, Pa.</u>		24a. REC'D BY REGISTRAR <u>July 31, 1956</u>	
24b. REGISTRAR'S SIGNATURE <u>Charles Bowers</u>							

CERTIFICATE OF DEATH

BUREAU V. 3

AUG 2 1956

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 7681 CERTIFICATE OF DEATH

07621

Reg. Dist. No. 361

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Washington</u>		STATE <u>Md.</u>		COUNTY <u>Washington</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Williamsport</u>		LENGTH OF STAY (In this place) <u>1 1/2 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport Md.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Williamsport Sanatorium Md. 104 N. Oregon or Williamsport</u>		STREET ADDRESS (If rural give location) <u>233 N. Conococheague</u>					
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Clara</u> (Middle) <u>Matilda</u> (Last) <u>Blayer</u>				(Month) <u>July</u> (Day) <u>3</u> (Year) <u>1956</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Sept. 21, 1880</u>	9. AGE last birthday <u>75</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (State or foreign country) <u>Penn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Lewis Renner</u>				14. MOTHER'S MAIDEN NAME <u>Barbara Hagerman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT & ADDRESS <u>Helen Blayer - Williamsport Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
331X IMMEDIATE CAUSE (A) <u>Hypostatic pneumonia</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Cerebral vascular accident</u>				<u>1 year</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, lecture, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u>July 3, 1956</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 3, 1956</u> , to <u>July 3, 1956</u> , that I last saw the deceased alive on <u>July 3, 1956</u> , and that death occurred at <u>10:00 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Albert L. Zopf</u>				DATE SIGNED <u>July 5, 1956</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>7/5/56</u>		NAME OF CEMETERY OR CREMATORY <u>BROADFORDING Cemetery</u>		LOCATION (City, town, or county) (State) <u>BROADFORDING, MARYLAND</u>	
24. REC'D BY REGISTRAR <u>July 6-1956</u>		REGISTRAR'S SIGNATURE <u>E. Lee McElroy</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Albert L. Zopf</u> ADDRESS <u>Williamsport, Md.</u>			



CERTIFICATE OF DEATH

1. NAME OF DECEASED

2. PLACE OF DEATH

3. SEX

Male

4. AGE

None

No

BUREAU V. S.  
JUL 9 1956

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7642

## CERTIFICATE OF DEATH

Reg. Dist. No. 07622  
302

1. PLACE OF DEATH o. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown Md.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Williamsport Maryland</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Washington County Hospital</b>		d. STREET ADDRESS <b>23 N. Conococheague Street</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>MAURICE</b> Last <b>BOWSER</b>		4. DATE OF DEATH Month <b>July</b> Day <b>30</b> Year <b>19 56</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 23 1904</b>
9. AGE (In years last birthday) <b>52</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>2</b> Days <b>6</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Conservation Aide</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Seed. Field Soil Conservation</b>	
11. BIRTHPLACE (State or foreign country) <b>Williamsport</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>John Bowser</b>		14. MOTHER'S MAIDEN NAME <b>Emma Jane Wolf</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-18-2136</b>	
17. INFORMANT <b>Mrs. Virginia Bowser Williamsport Md.</b>		23 N Conococheague	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ca pneumonia &amp; lung bronchio- 162x DUE TO genetic metastasis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b></b> DUE TO (c) <b></b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. <b>19</b> p. m. <b></b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b></b>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>7/30/56</b> , 19____, to <b>7/30/56</b> , 19____, that I last saw the deceased alive on <b>7/30/56</b> , 19____, and that death occurred on <b>7/30/56</b> , 19____, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Edith V. Seal</b> M.D.		DATE SIGNED <b>7/31/56</b>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Aug. 2 1956</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Riverview Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Williamsport Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edith V. Seal</b>		24a. REC'D BY REGISTRAR <b>Aug 3, 1956</b>	24b. REGISTRAR'S SIGNATURE <b>Phasit Bowser</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7643

## CERTIFICATE OF DEATH

Reg. Dist. No. 07623

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown Maryland</b>				c. LENGTH OF STAY IN 1b <b>25yrs</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>102 West Bethel Street</b>				d. STREET ADDRESS <b>102 West Bethel Street</b>			
3. NAME OF DECEASED (Type or print) First <b>Lena</b> Middle <b>May</b> Last <b>Butler</b>				4. DATE OF DEATH Month <b>July</b> Day <b>3</b> Year <b>1956</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 24 1912</b>	
9. AGE (In years last birthday) <b>44</b> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Women's Club</b>		11. BIRTHPLACE (State or foreign country) <b>Williamsport, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>				13. FATHER'S NAME <b>Roy Eggar Butler</b>			
14. MOTHER'S MAIDEN NAME <b>Harriet Brown</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>			
16. SOCIAL SECURITY NO. <b>219-30-0464</b>				17. INFORMANT <b>Mrs Harriet Butler</b> Address <b>325 N Jonathan</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>pulmonary embolism</b> <b>454 x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>thrombosis of femoral veins</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>acute psychosis</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. 11. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>6/24/56</b> , 19 <b>55</b> , to <b>7/3/56</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>6/21/56</b> , 19 <b>56</b> , and that death occurred at <b>9:30AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Howard N. Weeks</b>				ADDRESS (Street, city or town, state) <b>136 N. Potomac St., Hagerstown, Md.</b>			
PHYSICIAN'S NAME (Type) <b>Howard N. Weeks, M.D.</b>				DATE SIGNED <b>7/6/56</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-7-1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Riverview Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Williamsport Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John R Watson</b>				ADDRESS <b>Hagerstown Md</b>		24a. REC'D BY REGISTRAR <b>July 8, 1956</b>	
				24b. REGISTRAR'S SIGNATURE <b>W. H. Bowers</b>			

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
JAMES H. HARRIS		65		M		W		JUL 10 1956		BOSTON, MASS.	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE NO.		REGISTRATION NO.	
100 WASHINGTON ST.		CLOCK REPAIRER		HEART DISEASE		NATURAL		100		100	
DATE OF BIRTH		PLACE OF BIRTH		EDUCATION		MARRIAGE		SINGLE		MARRIED	
JUL 10 1956		MASSACHUSETTS		HIGH SCHOOL		MARRIED		MARRIED		MARRIED	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE NO.		REGISTRATION NO.	
JUL 10 1956		BOSTON, MASS.		HEART DISEASE		NATURAL		100		100	
DATE OF BIRTH		PLACE OF BIRTH		EDUCATION		MARRIAGE		SINGLE		MARRIED	
JUL 10 1956		MASSACHUSETTS		HIGH SCHOOL		MARRIED		MARRIED		MARRIED	

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JUL 10 1956

RECEIVED



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07624

7644

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>5 hrs</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>C.</b> Middle <b>MATILDA</b> Last <b>CHARNOCK</b>				4. DATE OF DEATH Month <b>July</b> Day <b>17</b> Year <b>1956</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 14, 1871</b>	
9. AGE (In years last birthday) <b>85</b> yrs.		IF UNDER 1 YEAR Months <b>0</b> Days <b>13</b>		IF UNDER 24 HRS. Hours <b>13</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Wheeling, W. Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>John Belleville</b>				14. MOTHER'S MAIDEN NAME <b>Julia Kruckenberg</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Mrs. Myrtle I. Cooley</b> Address <b>Hagerstown, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive Vascular Disease</b> DUE TO (c) <b>5 yrs. +</b>							INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>July 27, 1956</b> , to <b>July 27, 1956</b> , that I last saw the deceased alive on <b>July 27, 1956</b> , and that death occurred at <b>10:15 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>214 N. Potomac St. Hagerstown, Md.</b> DATE SIGNED <b>7/27/56</b>							
ACTUAL SIGNATURE <b>Clyde A. Hoffman</b> M.D.				PHYSICIAN'S NAME (Type) <b>Clyde A. Hoffman</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>7/30/1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Greenwood Cemetery</b>	
22d. LOCATION (City, town, or county) (State) <b>Wheeling, W. Virginia</b>							
23. FUNERAL DIRECTOR'S SIGNATURE <b>Suter - Rouzer Funeral Home</b> <b>R. Chandler Rouzer</b>				ADDRESS <b>Hagerstown, Md.</b>		24a. REC'D BY REGISTRAR <b>Aug 2, 1956</b>	
24b. REGISTRAR'S SIGNATURE <b>W. H. Bowers</b>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07625

7645

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 45 YEARS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON COUNTY HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MIDDLE LAST RALPH ARTHUR COOMBS		4. DATE OF DEATH Month Day Year 7 I 19 56	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH AUG 26, 1906
9. AGE (In years last birthday) 49 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SUPT OF SIGNAL DEPT		10b. KIND OF BUSINESS OR INDUSTRY CITY OF HAGERSTOWN	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ARTHUR W. COOMBS		14. MOTHER'S MAIDEN NAME MARGARET E. WILT	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. None	
17. INFORMANT MRS. JOHN L. NADENBOUSCH		Address MARTINSBURG, W. VA.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 1 hr 4 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1, 1956, to July 1, 1956, that I last saw the deceased alive on July 1, 1956, and that death occurred at 2:30 PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Louis G. Grotto M.D. 119 E. Hattie Ave 7/2/56 Hagerstown MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 7/3/56	
22c. NAME OF CEMETERY OR CREMATORY LUTHERN CEMETERY		22d. LOCATION (City, town, or county) (State) TANEYTOWN MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraus		ADDRESS Hagerstown, Md	
24a/ REC'D BY REGISTRAR July 3, 1956		24b. REGISTRAR'S SIGNATURE Chas. H. Bowers	

BUREAU A. S.

JUL 5 1956

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7646

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				d. STREET ADDRESS <u>128 N. Jonathan Street</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>JAMES WESTLEY COSTLEY</u>				4. DATE OF DEATH Month Day Year <u>July 2 1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>October 2, 1875</u>	9. AGE (In years last birthday) <u>80 yrs.</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Welfare Office</u>		Address <u>Hagerstown, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis C-V disease</u> DUE TO (c) <u>Generalized atherosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u> <u>Unknown</u> <u>Unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertensive C-V disease</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 25, 1956</u> , to <u>July 2, 1956</u> , that I last saw the deceased alive on <u>July 2, 1956</u> , and that death occurred at <u>8:15 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>L. L. Parker, Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>1145 W. Washington St.</u>		DATE SIGNED <u>7/6/56</u>	
PHYSICIAN'S NAME (Type) <u>L. L. Parker, Jr., M.D.</u>				<u>Hagerstown, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>7/11/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Washington County Home</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John R. Watson</u>				ADDRESS <u>Hagerstown Md</u>		24b. REGISTRAR'S SIGNATURE <u>John H. Bowers</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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may be returned by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7647

CERTIFICATE OF DEATH

07628

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>2 months</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				d. STREET ADDRESS <u>415 W. Franklin Street</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>IRWINE</u> Last <u>DAVIS</u>				4. DATE OF DEATH Month <u>July</u> Day <u>21</u> Year <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 22, 1874</u>		9. AGE (In years last birthday) <u>82</u> yrs.	IF UNDER 1 YEAR Months <u>5</u> Days <u>29</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Janitor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bd. of Education</u>		11. BIRTHPLACE (State or foreign country) <u>Keedysville, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Cornelius C. Davis</u>				14. MOTHER'S MAIDEN NAME <u>Eveline V. Brenner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Lester Davis</u>		Address <u>Philadelphia, Penn.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the stomach advanced</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>Not known</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 22, 1952</u> to <u>July 21, 1956</u> , that I last saw the deceased alive on <u>July 20, 1956</u> , and that death occurred at <u>10:30 A.</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>B. B. Kneisley</u>				ADDRESS (Street, city or town, state) <u>148 W. Washington St.,</u>		DATE SIGNED <u>7/23/56</u>	
PHYSICIAN'S NAME (Type) <u>B. B. Kneisley, M.D.</u>				<u>Hagerstown</u>		<u>Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/24/1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Suter - Rouzer Funeral Home</u>				ADDRESS <u>Hagerstown, Md.</u>		24. REC'D BY REGISTRAR <u>July 23, 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>Phyllis Jowers</u>			

RECEIVED

JUL 25 1956

BUREAU V. S.

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 HAGERSTOWN</b>				c. LENGTH OF STAY IN 1b <b>LIFE</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MARTIN MANOR REST HOME</b>				d. STREET ADDRESS <b>1223 VIRGINIA AVENUE</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>LILLIE</b> Middle <b>M. EICHELBERGER</b> Last <b></b>				4. DATE OF DEATH Month <b>7</b> Day <b>14</b> Year <b>19 56</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JAN 9, 1877</b>	
9. AGE (In years last birthday) yrs. <b>79</b>		IF UNDER 1 YEAR Months <b></b> Days <b></b> Hours <b></b> Min. <b></b>		IF UNDER 24 HRS. Months <b></b> Days <b></b> Hours <b></b> Min. <b></b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOL USEWORK</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>FRED MOWEN</b>				14. MOTHER'S MAIDEN NAME <b>SUSAN EVERHART</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>MRS. VIOLET WEAVER</b> Address <b>HAGERSTOWN, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Severe Arterio Sclerotic Heart Disease</b> <b>420.0</b> DUE TO <b>With myocardial failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <b></b> DUE TO (c) <b></b>							INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs +</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <b>11</b> p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>Jan 13, 1956</b> , to <b>July 14, 1956</b> , that I last saw the deceased alive on <b>July 13, 1956</b> , and that death occurred at <b>9:30 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>F F Lusby</b>				ADDRESS (Street, city or town, state) <b>230 N Potomac Hagerstown Md</b>			
PHYSICIAN'S NAME (Type) <b>F F Lusby</b>				DATE SIGNED <b>14 July 56</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>7/18/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>ROSE HILL CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>HAGERSTOWN MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Fred W. Kraiss, Hagerstown</b>				ADDRESS <b>Hagerstown Md</b>		24b. REGISTRAR'S SIGNATURE <b>Black &amp; Bowers</b>	
24a. REC'D BY REGISTRAR <b>July 17, 1956</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

JUL 19 1956

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7649

## CERTIFICATE OF DEATH

Reg. Dist. No. 07600 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>647 Sunset Ave.</b>				d. STREET ADDRESS <b>647 Sunset Ave.</b>			
3. NAME OF DECEASED (Type or print) <b>Roberta Virginia Elliott</b>				4. DATE OF DEATH <b>July 12 19 56</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 7, 1882</b>	9. AGE (In years last birthday) <b>73</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Scotland Pa.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>W. Augustus Bittinger</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Smith</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>----</b>		17. INFORMANT <b>Bruce A. Elliott Hagerstown Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>153X</b> DUE TO <b>Cerebral arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6-1-53</b> , to <b>7-12-56</b> , that I last saw the deceased alive on <b>7-12-56</b> , and that death occurred at <b>5:15 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>S. F. Minnich</b>				ADDRESS (Street, city or town, State) <b>Hagerstown Md.</b>			
PHYSICIAN'S NAME (Type) <b>DR E. W. Elliott Jr</b>				DATE SIGNED <b>July 14 1956</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-15-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		22d. LOCATION (City, town, or County) (State) <b>Hagerstown Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son</b>				24. REC'D BY REGISTRAR <b>July 14 1956</b>			
				24b. REGISTRAR'S SIGNATURE <b>Blair H. Bowers</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 1 of 2 should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race		Date of Death		Place of Death	
Robert A. Millett		47 years		Male		White		July 17, 1956		Baltimore, Md.	
Usual Residence		Cause of Death		Manner of Death		Occupation		Signature of Physician		Signature of Registrar	
Baltimore, Md.		Heart Disease		Natural		None		[Signature]		[Signature]	
Date of Birth		Date of Death		Time of Death		Hour of Death		Day of Death		Month of Death	
July 17, 1956		July 17, 1956		10:30 AM		10:30 AM		July 17, 1956		July 1956	
Place of Birth		Place of Death		Place of Death		Place of Death		Place of Death		Place of Death	
Baltimore, Md.		Baltimore, Md.		Baltimore, Md.		Baltimore, Md.		Baltimore, Md.		Baltimore, Md.	
Date of Death		Date of Death		Date of Death		Date of Death		Date of Death		Date of Death	
July 17, 1956		July 17, 1956		July 17, 1956		July 17, 1956		July 17, 1956		July 1956	
Place of Death		Place of Death		Place of Death		Place of Death		Place of Death		Place of Death	
Baltimore, Md.		Baltimore, Md.		Baltimore, Md.		Baltimore, Md.		Baltimore, Md.		Baltimore, Md.	
Date of Death		Date of Death		Date of Death		Date of Death		Date of Death		Date of Death	
July 17, 1956		July 17, 1956		July 17, 1956		July 17, 1956		July 17, 1956		July 1956	
Place of Death		Place of Death		Place of Death		Place of Death		Place of Death		Place of Death	
Baltimore, Md.		Baltimore, Md.		Baltimore, Md.		Baltimore, Md.		Baltimore, Md.		Baltimore, Md.	

BUREAU V. 5

JUL 17 1956

RECEIVED

Robert T. Wainwright & Son, Baltimore, Md.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

7682

17651  
302

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Deleware</u> b. COUNTY <u>Yorklyn</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Hagerstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Yorklyn</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Gateway Convalescent Home</u>				d. STREET ADDRESS <u>102 E. State Street</u>			
3. NAME OF DECEASED (Type or print) First <u>GEORGE</u> Middle <u>WILLIAM</u> Last <u>FULLER</u>				4. DATE OF DEATH Month <u>July</u> Day <u>11</u> Year <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 21, 1880</u>		9. AGE (In years last birthday) <u>75</u> yrs.	IF UNDER 1 YEAR Months <u>11</u> Days <u>20</u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Coredcoils</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Plastic Industry</u>		11. BIRTHPLACE (State or foreign country) <u>Clarke County, Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Alonzo M. Fuller</u>				14. MOTHER'S MAIDEN NAME <u>Hattie L. Rodeffer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>221-03-8878</u>		17. INFORMANT Address <u>Howard E. Fuller Hagerstown, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Spine</u> <u>196X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>  </u> DUE TO (c) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>  </u> p. m. <u>  </u> 19 <u>56</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 20, 1956</u> to <u>July 11, 1956</u> that I last saw the deceased alive on <u>July 11, 1956</u> and that death occurred at <u>5:00 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>David R. Brewer</u> M.D.				ADDRESS (Street, city or town, state) <u>Clear Spring Md</u>			
PHYSICIAN'S NAME (Type) <u>David R Brewer</u>				DATE SIGNED <u>7/13/56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/14/1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Suter-Houzer Funeral Home</u> <u>R. Franklin Ringer</u>				ADDRESS <u>Hagerstown, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>7/17/56</u>	
				24b. REGISTRAR'S SIGNATURE <u>Larry M. Fickler</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES EARL RAY		35		M		W		JAN 5, 1928		MOBILE, ALABAMA	
MARRIAGE		DATE OF MARRIAGE		PLACE OF MARRIAGE		NAME OF SPOUSE		DATE OF DEATH		PLACE OF DEATH	
MARRIED		JAN 15, 1950		BALTIMORE, MARYLAND		JAMES EARL RAY		JUL 6, 1968		BALTIMORE, MARYLAND	
OCCUPATION		DATE OF OCCUPATION		PLACE OF OCCUPATION		NAME OF EMPLOYER		DATE OF DEATH		PLACE OF DEATH	
CONDUCTOR		JUL 1, 1968		BALTIMORE, MARYLAND		B&O RAILROAD		JUL 6, 1968		BALTIMORE, MARYLAND	
CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH		NAME OF PHYSICIAN		DATE OF DEATH		PLACE OF DEATH	
HEART DISEASE		SUICIDE		BALTIMORE, MARYLAND		JAMES EARL RAY		JUL 6, 1968		BALTIMORE, MARYLAND	
DETAILS OF DEATH		DATE OF DEATH		PLACE OF DEATH		NAME OF PHYSICIAN		DATE OF DEATH		PLACE OF DEATH	
HEART DISEASE		JUL 6, 1968		BALTIMORE, MARYLAND		JAMES EARL RAY		JUL 6, 1968		BALTIMORE, MARYLAND	
DETAILS OF DEATH		DATE OF DEATH		PLACE OF DEATH		NAME OF PHYSICIAN		DATE OF DEATH		PLACE OF DEATH	
HEART DISEASE		JUL 6, 1968		BALTIMORE, MARYLAND		JAMES EARL RAY		JUL 6, 1968		BALTIMORE, MARYLAND	

BUREAU V. 3

JUL 23 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7650

## CERTIFICATE OF DEATH

Reg. Dist. No.

07632

302

1. PLACE OF DEATH o. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>None</b>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Hagerstown</b>				X			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>				d. STREET ADDRESS <b>Route 5</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Robert</b> Middle <b>Russell</b> Last <b>Gearhart</b>				4. DATE OF DEATH Month <b>July</b> Day <b>15</b> Year <b>1956</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 14, 1956</b>		9. AGE (In years last birthday) yrs. <b>12</b>	IF UNDER 1 YEAR Months <b>12</b> Days <b>12</b>	IF UNDER 24 HRS. Min. <b>12</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Hagerstown, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Robert Milton Gearhart</b>				14. MOTHER'S MAIDEN NAME <b>Fannie Virginia Mason</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Robert M. Gearhart R #5 Hagerstown, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>762.5 atelectasis</b> DUE TO (b) <b>Immaturity</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <b>Immaturity</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Interval between onset and death from birth</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>7/14, 1956</b> , to <b>7/15, 1956</b> , that I last saw the deceased alive on <b>7/15, 1956</b> , 19 <b>56</b> , and that death occurred at <b>5:03 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>F. W. Dove Jr.</b>				ADDRESS (Street, city or town, state) <b>214 N. Potomac St. Hagerstown, Md.</b>			
PHYSICIAN'S NAME (Type) <b>Frederick D. Dove</b>				DATE SIGNED <b>July 16, 1956</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>July 16, 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. C. Frost</b>				ADDRESS <b>2081352 XVO</b>		24b. REGISTRAR'S SIGNATURE <b>Chas H Bowers</b>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

07633

302

7651

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>				c. LENGTH OF STAY IN 1b <b>50 YRS.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>521 N. MULBERRY ST.</b>				d. STREET ADDRESS <b>521 N. MULBERRY ST.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>DULCIA REEL GRAY</b>				4. DATE OF DEATH Month <b>JULY</b> Day <b>1</b> Year <b>19 56</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10/31/1875</b>	
9. AGE (In years lost birthday) <b>80</b> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>SAMUEL REEL</b>				14. MOTHER'S MAIDEN NAME <b>C. ANNE PRICE</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>MISS RHODA GRAY</b>		Address <b>HAGERSTOWN MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive cardiovascular disease</b> <b>443X</b> DUE TO Aortic aneurysm Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>3 yrs.</b> DUE TO (c) <b>10 yrs</b>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>None</b> 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 49</b> , to <b>July 1</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>July 1</b> , 19 <b>56</b> , and that death occurred at <b>4:10 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>S. Robert Wells</b>		M.D. <b>115 N. Potomac Street</b>		DATE SIGNED <b>7-2-56</b>			
PHYSICIAN'S NAME (Type) <b>S. Robert Wells, M.D.</b>		Hagerstown, Maryland					
22a. BURIAL, CREMATION, or other disposition (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>7/3/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven CEM.</b>		22d. LOCATION (City, town, or county) (State) <b>HAGERSTOWN MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. J. Norment</b>		ADDRESS <b>Hagerstown Md.</b>		24a. REC'D BY REGISTRAR <b>J. J. 5. 1956</b>		24b. REGISTRAR'S SIGNATURE <b>Blair H. Bowers</b>	

45-00

BUREAU V. S.

1956 6 JUN

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it as a "pending" certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar for a burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07634

Reg. Dist. No. 302

7652

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN lb 35 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 335 N. Locust St.				d. STREET ADDRESS 335 N. Locust St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) John Samuel Harmon				4. DATE OF DEATH Month July Day 4 Year 1956					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Apr. 27, 1870			
9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Finisher		10b. KIND OF BUSINESS OR INDUSTRY Furniture		11. BIRTHPLACE (State or foreign country) Near Myersville Md.		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME George Harmon				14. MOTHER'S MAIDEN NAME Martha Lum					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] No		16. SOCIAL SECURITY NO. -----		17. INFORMANT Address Mrs. Christinia Harmon Hagerstown Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. None 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE S. Robert Wells				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) S. Robert Wells, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-6-56		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son Hagerstown Md.				24a. REC'D BY REGISTRAR July 6, 1956		24b. REGISTRAR'S SIGNATURE B. H. Bowers			

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		RESIDENCE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF EXAMINER		DATE	



## CERTIFICATE OF DEATH

Dr Kneisley 07635

Reg. Dist. No. 302

7653

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>20 Yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1300 Hamilton Blvd</u>				d. STREET ADDRESS <u>1300 Hamilton Blvd</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>STELLA</u> Middle <u>YOUNG</u> Last <u>HARSHMAN</u>				4. DATE OF DEATH Month <u>July</u> Day <u>23</u> Year <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 11 1887</u>		9. AGE (In years last birthday) <u>69</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HRS. Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Myersville Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Elmer A. Young</u>				14. MOTHER'S MAIDEN NAME <u>Clara Harp</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>James L. Harshman Hagerstown Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary thrombosis</u> <u>420.1</u> DUE TO <u>Chronic hypertensive cardiovascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>with heart block and Stokes-Adams syndrome</u> DUE TO (c) <u>Coronary atherosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u> <u>10 yrs.</u> <u>Not known</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 22, 1956</u> to <u>July 22, 1956</u> that I last saw the deceased alive on <u>June 10, 1949</u> , and that death occurred at <u>9:30P M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>148 West Washington Street Hagerstown Maryland</u> DATE SIGNED <u>7/24/56</u>							
ACTUAL SIGNATURE <u>B. B. Kneisley</u>		M.D. <u>B. B. Kneisley, M.D. Hagerstown Maryland</u>					
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/26/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Wash. Co Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman Hagerstown Md.</u>				ADDRESS <u>Hagerstown Md.</u>		24a. REC'D BY REGISTRAR <u>July 30, 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>Shelley Bowers</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE

## CERTIFICATE OF DEATH

BUREAU V. S.

AUG 1 1956

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 22d Film 6202 8228-56 et

## CERTIFICATE OF DEATH

Reg. Dist. No. 202

07636

7654

1. PLACE OF DEATH o. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN lb <b>33 years</b>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				d. STREET ADDRESS <b>532 Salem Ave</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>532 Salem Ave,</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Annie</b> Middle <b>Elizabeth</b> Last <b>Hartranft</b>				4. DATE OF DEATH Month <b>July</b> Day <b>16</b> Year <b>1956</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>February 23, 1885</b>	
9. AGE (In years lost birthday) <b>71 yrs.</b>		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>		IF UNDER 24 HRS. Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Owm Home</b>		11. BIRTHPLACE (State or foreign country) <b>Hag. Rt. 4</b>		12. CITIZEN OF WHAT COUNTRY? <b>4</b>	
13. FATHER'S NAME <b>Norman B. Holsinger</b>				14. MOTHER'S MAIDEN NAME <b>Eliza Jane Myers</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>---</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>---</b>		17. INFORMANT Address <b>H. Leroy Hartranft Hagerstown Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>442X</b> DUE TO <b>Cerebro-vascular disease</b> (b) <b>Poly arthritis</b> DUE TO <b></b> (c) <b></b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>						INTERVAL BETWEEN ONSET AND DEATH <b>4 yrs</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b></b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b></b>		20f. (City or town) (County) (State) <b></b>	
21. I certify that I attended the deceased from <b>Aug 1 - 1953</b> to <b>July 16, 1956</b> , that I last saw the deceased alive on <b>July 16, 1956</b> , and that death occurred at <b>532 Salem Ave</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Dr. E. W. Dittus</b>		M.D. <b>Hagerstown Md</b>		ADDRESS (Street, city or town, state) <b>Hagerstown Md</b>		DATE SIGNED <b>7/16/56</b>	
PHYSICIAN'S NAME (Type) <b>Dr. E. W. Dittus</b>		M.D. <b>Hagerstown Md</b>		ADDRESS (Street, city or town, state) <b>Hagerstown Md</b>		DATE SIGNED <b>7/16/56</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-19-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Grove Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Near Cearfoss Md. Penn.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son</b>				ADDRESS <b>Hagerstown Md.</b>		24. REC'D BY REGISTRAR <b>July 30, 1956</b>	
				24b. REGISTRAR'S SIGNATURE <b>W. H. Bowers</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be removed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use of the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED ANNIE ALLEN		AGE 72 years		SEX Female	
DATE OF DEATH JUL 23 1956		PLACE OF DEATH Home		CITY Baltimore	
RESIDENCE 323 Salem Ave		OCCUPATION None		CAUSE OF DEATH Heart failure	
DATE OF BIRTH JUL 10 1884		PLACE OF BIRTH Maryland		MANNER OF DEATH Natural	
NAME OF DECEASED ANNIE ALLEN		AGE 72 years		SEX Female	
DATE OF DEATH JUL 23 1956		PLACE OF DEATH Home		CITY Baltimore	
RESIDENCE 323 Salem Ave		OCCUPATION None		CAUSE OF DEATH Heart failure	
DATE OF BIRTH JUL 10 1884		PLACE OF BIRTH Maryland		MANNER OF DEATH Natural	

BUREAU V. S.

JUL 23 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07637

7655

## CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH o. COUNTY <b>WASHINGTON</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>NONE</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b> d. STREET ADDRESS <b>725 INTERVAL ROAD</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>LUELLA VIRGINIA HAWKINS</b>				4. DATE OF DEATH Month Day Year <b>JULY 15, 1956</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>SEPT. 20, 1877</b>	9. AGE (In years last birthday) <b>78</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>		11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>HENRY PADGETT</b>			14. MOTHER'S MAIDEN NAME <b>MARY O'FERREL</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>MRS. VIRGINIA H. FORNEY - HAGERSTOWN, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>450.0</b> DUE TO <b>Uremia &amp; arteriosclerotic</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arteriosclerosis</b> DUE TO (c) <b>years</b>						INTERVAL BETWEEN ONSET AND DEATH <b>sev. days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Hagerstown, Maryland</b>		(County) (State)		
21. I certify that I attended the deceased from <b>2/6/56</b> , 19____, to <b>7/13/56</b> , 19____, that I last saw the deceased alive on <b>7/13/56</b> , 19____, and that death occurred at <b>10:35 M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>136 North Potomac St., Hagerstown, Maryland</b> DATE SIGNED <b>7/21/56</b>							
ACTUAL SIGNATURE <b>Howard N. Weeks</b>		M.D. <b>136 North Potomac St., Hagerstown, Maryland</b>					
PHYSICIAN'S NAME (Type) <b>Howard N. Weeks, M.D.</b>		Hagerstown, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>7/17/1956</b>	22c. NAME OF CEMETERY OR CREMATORY <b>MOUNT HEBRON CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>WINCHESTER, VIRGINIA</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lauren Jones - Winchester, Va.</b>		ADDRESS <b>Winchester, Va.</b>		24a. REC'D BY REGISTRAR <b>DATE JUL 30 1956</b>	24b. REGISTRAR'S SIGNATURE <b>Chas. Bewers</b>		



CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, time, place, cause, and signature. The form is mostly blank with some faint markings.

RECEIVED  
JUL 30 1956  
BUREAU V. S.

James Lee Winchester

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PK-3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for a burial, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Dr wells  
Reg. Dist. No. 302

7656

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN lb <u>59 Yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>236 East Antietam St.</u>				d. STREET ADDRESS <u>236 E st Antietam St</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>LOTTIE</u> Middle <u>BELLE</u> Last <u>HESS</u>				4. DATE OF DEATH Month <u>July</u> Day <u>15</u> Year <u>1956</u> 19			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 28 1870</u>	9. AGE (In years last birthday) <u>85</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Harney Carroll Co Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John G. Hess</u>				14. MOTHER'S MAIDEN NAME <u>Agnes T. Baker</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Miss Emma M. Hess 236 E. Antietam &amp; Hagerstown Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Malignancy of breast</u> DUE TO <u>arteriosclerotic myocardial heart disease with failure grade iv</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> (c) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH <u>  </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>none</u> 19 p. m. <u>  </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>none</u>	20f. (City or town) <u>  </u>	(County) <u>  </u>	(State) <u>  </u>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>S. Robert Wells</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>S. Robert Wells, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/17/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Wash. Co Md</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>				ADDRESS <u>Hagerstown Md.</u>		24a. REC'D BY REGISTRAR <u>July 19 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. H. Bowers</u>			

MALE AND STATEMENT OF HEALTH-BATHING 10  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 2

JUL 23 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07639

7657

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>				c. LENGTH OF STAY IN 1b <b>4 MO.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>856 JEFFERSON ST.</b>				d. STREET ADDRESS <b>MT. LENA</b>			
3. NAME OF DECEASED (Type or print) First <b>LEILA</b> Middle <b>MAY</b> Last <b>HIGMAN</b>				4. DATE OF DEATH Month <b>JULY</b> Day <b>14</b> Year <b>19 56</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/22/1885</b>	9. AGE (In years last birthday) <b>71</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>DANIEL W. MANGES</b>				14. MOTHER'S MAIDEN NAME <b>ANNA COST</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>214-09-9172</b>		17. INFORMANT <b>MRS. ANNALE MILLER</b>		<b>HAGERSTOWN MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchiectasis</b> 241X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Pulmonary Emphysema</b> DUE TO (c) <b>Bronchial asthma</b>						INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b> <b>2 years</b> <b>18 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>April 1, 19 56</b> to <b>July 14, 19 56</b> that I last saw the deceased alive on <b>July 14, 19 56</b> , and that death occurred at <b>1:15 p.m.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>214 N. Potomac Street</b> DATE SIGNED <b>7-16-56</b>							
ACTUAL SIGNATURE <b>Lloyd A. Hoffman</b> M.D.				PHYSICIAN'S NAME (Type) <b>Lloyd A. Hoffman, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				22b. DATE THEREOF <b>7/17/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>BEAVER CREEK CEM.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. Z. Korman</b>				24. REC'D BY REGISTRAR <b>July 18, 1956</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. Bowers</b>	

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Dr. Lusby • 7658

## CERTIFICATE OF DEATH

Reg. Dist. No.

07640  
302

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>7 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>119 South Locust St.</u>				d. STREET ADDRESS <u>119 South Locust St.</u>			
3. NAME OF DECEASED (Type or print) First <u>NELLIE</u> Middle <u>KATE</u> Last <u>HINES</u>				4. DATE OF DEATH Month <u>July</u> Day <u>3</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 26, 1874</u>	
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Sharpsburg, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>David Spong</u>				14. MOTHER'S MAIDEN NAME <u>Anna D. Burns</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Miss Martha Hines-119 S. Locust-Hag.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Liver (Primary)</u> <u>155X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs +</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>May 1</u> , 19 <u>56</u> , to <u>3 July</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>2 July</u> , 19 <u>56</u> , and that death occurred at <u>12:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>F. F. Lusby</u>				DATE SIGNED <u>4 July 56</u>			
PHYSICIAN'S NAME (Type) <u>F. F. Lusby</u>				ADDRESS (Street, city or town, state) <u>230 N Potomac Hagerstown Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-6-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. View Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Sharpsburg, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman-Hagerstown, Maryland</u>				24. REC'D BY REGISTRAR <u>July 6, 1956</u> 24b. REGISTRAR'S SIGNATURE <u>Phasff Powers</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		MARRIAGE		OCCUPATION	
JAMES H. HARRIS		45		M		W		MARRIED		FARMER	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE NO.		REGISTERED	
JULY 6, 1956		BALTIMORE, MD.		HEART DISEASE		NATURAL		12345		YES	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF BURIAL	
J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	

*(Faint, illegible text, possibly a signature or stamp)*

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JUL 9 1956

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

7659

07641

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>	
c. LENGTH OF STAY IN 1b <b>2 1/2 weeks</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>		d. STREET ADDRESS <b>125 E. Lee St.,</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Izetta</b> Middle <b>Belle</b> Last <b>Hoch</b>		4. DATE OF DEATH Month <b>7</b> Day <b>18</b> Year <b>56</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 19, 1919</b>
9. AGE (In years lost birthday) <b>37</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>machine opr.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>L'Aiglon Apparel</b>	11. BIRTHPLACE (State or foreign country) <b>Hagerstown, Md.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>P. A. Limburg</b>		14. MOTHER'S MAIDEN NAME <b>Minnie B Schlier</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>214-09-9972</b>	17. INFORMANT <b>Luther A. Limburg Hagerstown, Md.</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma - Rt. Breast - metastatic</b> <b>170X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>18 mo.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <b>Aug 18, 1956</b> to <b>July 18, 1956</b> , that I last saw the deceased alive on <b>July 18, 1956</b> , and that death occurred at <b>4:30 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Philip J. Hirshman</b> M.D.		ADDRESS (Street, city or town, State) <b>159 W. Washington St., Hagerstown, Md.</b>	
DATE SIGNED <b>7/19/56</b>			
PHYSICIAN'S NAME (Type) <b>Philip J. Hirshman, M.D.</b>		159 W. Washington St., Hagerstown, Md. 7/19/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	22b. DATE THEREOF <b>7-21-56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill</b>	22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Fred W. Kraiss</b>		ADDRESS <b>Hagerstown, Md.</b>	
24a. REC'D BY REGISTRAR <b>7/23/1956</b>		24b. REGISTRAR'S SIGNATURE <b>Shasth Bowers</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

JUL 25 1956

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2, and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07642

7660

## CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 35 BRAXTON AVENUE		d. STREET ADDRESS 35 BRAXTON AVENUE	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last HOWARD HOUSEHOLDER		4. DATE OF DEATH Month Day Year 7 I 19 56	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG 9, 1895
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY DAY WORKER	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOSEPH HOUSEHOLDER		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 220-10-3897	
17. INFORMANT MRS. MARGARET HOUSEHOLDER		Address HAGERSTOWN, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic myocardial heart disease 420.1 DUE TO acute coronary occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 8 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Paralysis Agitans		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. none 19 p. m.		20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State) - - -	
21. I certify that I attended the deceased from Oct. 1950, to July 1, 1956, that I last saw the deceased alive on June 28, 1956, and that death occurred at 5 A. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 115 N. Potomac Street 7-2-56 ACTUAL SIGNATURE S. Robert Wells M.D. PHYSICIAN'S NAME (Type) S. Robert Wells, M.D. Hagerstown, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 7/3/56	
22c. NAME OF CEMETERY OR CREMATORY PINE GROVE CEMETERY		22d. LOCATION (City, town, or county) (State) MERCERSBURG PENNA.	
23. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss		ADDRESS Hagerstown, Md.	
24. REC'D BY REGISTRAR July 31 1956		24b. REGISTRAR'S SIGNATURE Clash Bowers	



JUL 5 1956

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

7683

## CERTIFICATE OF DEATH

07643

Reg. Dist. No. 301

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Washington Co.</u>		MARYLAND		STATE <u>Pa.</u>		COUNTY <u>FRANKLIN</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>		LENGTH OF STAY (in this place) <u>1 yr. 2 mo.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chambersburg</u>		<u>75x-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Williamsport Sanitarium</u> <u>154 N. Fitzgerald</u>				STREET ADDRESS (If rural give location) <u>55 Riddle Rd.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Mary</u> (Middle) <u>M.</u> (Last) <u>Johnston</u>				(Month) <u>July</u> (Day) <u>5</u> (Year) <u>1956</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>May 20, 1887</u>	9. AGE last birthday <u>69</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during, most of working life, even if retired) <u>School Teacher</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Private Schools</u>		11. BIRTHPLACE (State or foreign country) <u>New German Town, PA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Alexander Armstrong Johnston</u>				14. MOTHER'S MAIDEN NAME <u>Armintha Alexander</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Dr. R.R. Johnston</u> <u>323 W. Fairview Ave., Dayton Ohio.</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>350X</u>				Parkinson's Disease			
ANTECEDENT CAUSE(S) DUE TO				INTERVAL BETWEEN ONSET AND DEATH <u>20 years</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 1, 1955</u> to <u>July 5, 1956</u> , that I last saw the deceased alive on <u>July 4, 1956</u> , and that death occurred at <u>3:55 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Wm. H. Hark</u>				ADDRESS (Street, city, town, state) <u>Wills Camp, Md.</u>			
DATE SIGNED <u>July 2</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>JULY 7, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>NORLAND CEM.</u>		LOCATION (City, town, or county) (State) <u>CHAMBERSBURG, PA.</u>	
24. REC'D BY REGISTRAR <u>July 7-1956</u>		REGISTRAR'S SIGNATURE <u>E Lee McElroy</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. Franklin Boyer</u>		ADDRESS <u>Gazettown, Maryland</u>	

240700024

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

1. NAME OF DECEASED: [Faint text]

2. SEX: [Faint text]

3. AGE: [Faint text]

4. DATE OF BIRTH: [Faint text]

5. PLACE OF BIRTH: [Faint text]

6. OCCUPATION: [Faint text]

7. CAUSE OF DEATH: [Faint text]

8. PLACE OF DEATH: [Faint text]

9. TIME OF DEATH: [Faint text]

10. SIGNATURE: [Faint text]

11. DATE: [Faint text]

12. BY: [Faint text]

13. [Faint text]

14. [Faint text]

15. [Faint text]

16. [Faint text]

17. [Faint text]

18. [Faint text]

19. [Faint text]

20. [Faint text]

21. [Faint text]

22. [Faint text]

23. [Faint text]

24. [Faint text]

25. [Faint text]

26. [Faint text]

27. [Faint text]

28. [Faint text]

29. [Faint text]

30. [Faint text]

31. [Faint text]

32. [Faint text]

33. [Faint text]

34. [Faint text]

35. [Faint text]

36. [Faint text]

37. [Faint text]

38. [Faint text]

39. [Faint text]

40. [Faint text]

41. [Faint text]

42. [Faint text]

43. [Faint text]

BUREAU V. 2

JUL 10 1956

RECEIVED

\* 7684

## CERTIFICATE OF DEATH

Reg. Dist. No. 305

07644

1. PLACE OF DEATH o. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BENEVOLE - RURAL</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BENEVOLE - RURAL</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>BOONSBORO MD. R.I.</u>				d. STREET ADDRESS <u>BOONSBORO MD. R.I.</u>			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>SAMUEL C. KAYLOR</u>				4. DATE OF DEATH <u>JULY - 19 - 1956</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAY - 14 - 1887</u>	
9. AGE (In years lost birthday) <u>68</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>OFFICER - WASH. CO. JUVENILE COURT</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>BEAVER CREEK WASH. CO. MD. U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>JOHN W. KAYLOR</u>				14. MOTHER'S MAIDEN NAME <u>J. SOURI FUNK</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>219-36-2542</u>		17. INFORMANT Address <u>MRS. NELLIE KAYLOR BOONSBORO MD. RI</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis due to arteriosclerotic heart disease</u> 480.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>heart disease</u> DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arthritis, rheumatoid, vertebral</u> 1 1/2 years							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>June 13</u> , 19 <u>56</u> , to <u>July 19</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>July 16</u> , 19 <u>56</u> , and that death occurred at <u>10:20 AM</u> , from the causes and on the date stated above. D.S.T. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>W. T. Layman</u>				M.D. <u>100 Professional Arts Bldg. 4272</u>			
PHYSICIAN'S NAME (Type) <u>William T. Layman, M.D.</u>				<u>Hagerstown, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JULY - 22 - 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CHURCH OF THE BRETHREN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>BEAVER CREEK MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>BAST FUNERAL HOME</u>				ADDRESS <u>BOONSBORO MD</u>		24a. REC'D BY REGISTRAR <u>John H. Paul</u>	
24b. REGISTRAR'S SIGNATURE							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DR. W. T. LAYMAN  
PROFESSIONAL ARTS BLDG.

**BUREAU V. S.**

JUL 24 1956

RECEIVED



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07645

CERTIFICATE OF DEATH

Reg. Dist. No. 302

7661

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>61 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown M</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>				d. STREET ADDRESS <b>927 Mulberry Ave.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Mayalda B Kiracofe</b>				4. DATE OF DEATH <b>July 13 1956</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 26, 1873</b>		9. AGE (In years last birthday) <b>82 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Mt. Pleasant Fred. Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>George S. Fox</b>				14. MOTHER'S MAIDEN NAME <b>Mary Fitz</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Miss Ilda M. Kiracofe Hagerstown Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiovascular Collapse</b> <b>234x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Ovarian Tumor</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cerebral Vas. Accident.</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1954</b> , 19____, to <b>July 13, 1956</b> , that I last saw the deceased alive on <b>July 12, 1956</b> , and that death occurred at <b>7 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Louis G. Pratt</b>				ADDRESS (Street, city or town, state) DATE SIGNED <b>July 14, 1956</b>			
PHYSICIAN'S NAME (Type) <b>Louis G. Pratt</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-16-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son</b>				ADDRESS <b>Hagerstown Md.</b>			
24. REC'D BY REGISTRAR <b>July 14, 1956</b>				24b. REGISTRAR'S SIGNATURE <b>Blair H. Bowers</b>			

CERTIFICATE OF DEATH

1956

Name of Deceased		Date of Death		Place of Death	
John Doe		10/15/56		Baltimore, Md.	
Age		Sex		Race	
65 years		Male		White	
Married		Occupation		Cause of Death	
Yes		Retired		Heart Disease	
Date of Birth		Place of Birth		Date of Admission to Hospital	
10/15/1891		Baltimore, Md.		10/10/56	
Name of Physician		Name of Hospital		Name of Undertaker	
Dr. J. Doe		St. Mary's Hospital		John Doe	
Signature of Physician		Signature of Hospital		Signature of Undertaker	
[Signature]		[Signature]		[Signature]	

BUREAU V. S.

OCT 17 1956

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Dr Bell

07646  
302

7662

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>35 Yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>226 East Franklin St</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>BENJAMIN JACOB LECKRON</u>				4. DATE OF DEATH Month Day Year <u>July 4 1956 19</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 23 1874</u>		9. AGE (In years last birthday) <u>81</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Fire Truck Driver Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>USA</u>	
13. FATHER'S NAME <u>John Leckron</u>				14. MOTHER'S MAIDEN NAME <u>Fannie Kauffman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>Spanish Amer</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Miss Alice Leckron 226 E. Franklin St</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sarcoma of Urinary Bladder</u> <u>181X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized Arteriosclerosis.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 months</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb. 10, 1956</u> , to <u>July 4, 1956</u> , that I last saw the deceased alive on <u>July 2, 1956</u> , and that death occurred at <u>1:00AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>119 North Potomac St., July 6, 1956</u>							
ACTUAL SIGNATURE <u>R. A. Bell</u> M.D.				PHYSICIAN'S NAME (Type) <u>R. A. Bell</u> <u>Hagerstown, Maryland.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/6/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Pauls Cemetery near Clearspring Wash Co Md.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Andrew K. Coffman Hagerstown Md.</u>				24a. REC'D BY REGISTRAR <u>July 6, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Chas H Powers</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

BUREAU V. S.

JUL 9 1956

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **302**

<b>7685</b>				<b>07647</b>			
1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Leitersburg</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>On Highway</u>				d. STREET ADDRESS <u>1017 Main Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>LESTER</u> <u>EUGENE</u> <u>LUSHBAUGH</u>				4. DATE OF DEATH Month Day Year <u>July 20,</u> <u>19 56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>September 18, 1921</u>		9. AGE (In years last birthday) <u>34</u> yrs.	IF UNDER 1 YEAR Months <u>10</u> Days <u>2</u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Loader</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Trucking company</u>		11. BIRTHPLACE (State or foreign country) <u>Big Poole, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Lester Lushbaugh</u>				14. MOTHER'S MAIDEN NAME <u>Alice Gearhart</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		16. SOCIAL SECURITY NO. <u>W. W. LL 215-18-1683</u>		17. INFORMANT Address <u>Lester Lushbaugh Hagerstown, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fractured Skull</u>  <u>816X</u> DUE TO <u>Crushed chest ( Hemorrhage &amp; Shock)</u>            Conditions, if any, which gave rise to immediate cause (b) <u>  </u>            (c), stating the underlying cause lost. DUE TO <u>  </u> </p> </div> <div style="width: 35%;"> <p>INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u></p> </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Automobile skidded on wet highway crashed into another car</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>5:50</u> <u>PM</u> <u>July 20 19 56</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>		20f. (City or town) (County) (State) <u>Rural- Leitersburg, Wash., Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>S. Robert Wells</u>				DATE SIGNED <u>7-21-56</u>			
EXAMINER'S NAME (Type) <u>S. Robert Wells, M.D.</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/23/1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Franklin Royer</u>				24a. REC'D BY REGISTRAR <u>July 23, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Bowers</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MASSACHUSETTS DEPARTMENT OF HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased		2. Sex		3. Age	
4. Date of Death		5. Time of Death		6. Place of Death	
7. Cause of Death		8. Manner of Death		9. Signature of Medical Examiner	
10. Signature of Coroner		11. Signature of Registrar		12. Signature of Burial Officer	
13. Signature of Undertaker		14. Signature of Funeral Home		15. Signature of Cemetery	
16. Signature of Church		17. Signature of Minister		18. Signature of Rector	
19. Signature of Pastor		20. Signature of Vicar		21. Signature of Priest	
22. Signature of Chaplain		23. Signature of Minister of Religion		24. Signature of Minister of Religion	
25. Signature of Minister of Religion		26. Signature of Minister of Religion		27. Signature of Minister of Religion	
28. Signature of Minister of Religion		29. Signature of Minister of Religion		30. Signature of Minister of Religion	
31. Signature of Minister of Religion		32. Signature of Minister of Religion		33. Signature of Minister of Religion	
34. Signature of Minister of Religion		35. Signature of Minister of Religion		36. Signature of Minister of Religion	
37. Signature of Minister of Religion		38. Signature of Minister of Religion		39. Signature of Minister of Religion	
40. Signature of Minister of Religion		41. Signature of Minister of Religion		42. Signature of Minister of Religion	
43. Signature of Minister of Religion		44. Signature of Minister of Religion		45. Signature of Minister of Religion	
46. Signature of Minister of Religion		47. Signature of Minister of Religion		48. Signature of Minister of Religion	
49. Signature of Minister of Religion		50. Signature of Minister of Religion		51. Signature of Minister of Religion	
52. Signature of Minister of Religion		53. Signature of Minister of Religion		54. Signature of Minister of Religion	
55. Signature of Minister of Religion		56. Signature of Minister of Religion		57. Signature of Minister of Religion	
58. Signature of Minister of Religion		59. Signature of Minister of Religion		60. Signature of Minister of Religion	
61. Signature of Minister of Religion		62. Signature of Minister of Religion		63. Signature of Minister of Religion	
64. Signature of Minister of Religion		65. Signature of Minister of Religion		66. Signature of Minister of Religion	
67. Signature of Minister of Religion		68. Signature of Minister of Religion		69. Signature of Minister of Religion	
70. Signature of Minister of Religion		71. Signature of Minister of Religion		72. Signature of Minister of Religion	
73. Signature of Minister of Religion		74. Signature of Minister of Religion		75. Signature of Minister of Religion	
76. Signature of Minister of Religion		77. Signature of Minister of Religion		78. Signature of Minister of Religion	
79. Signature of Minister of Religion		80. Signature of Minister of Religion		81. Signature of Minister of Religion	
82. Signature of Minister of Religion		83. Signature of Minister of Religion		84. Signature of Minister of Religion	
85. Signature of Minister of Religion		86. Signature of Minister of Religion		87. Signature of Minister of Religion	
88. Signature of Minister of Religion		89. Signature of Minister of Religion		90. Signature of Minister of Religion	
91. Signature of Minister of Religion		92. Signature of Minister of Religion		93. Signature of Minister of Religion	
94. Signature of Minister of Religion		95. Signature of Minister of Religion		96. Signature of Minister of Religion	
97. Signature of Minister of Religion		98. Signature of Minister of Religion		99. Signature of Minister of Religion	
100. Signature of Minister of Religion		101. Signature of Minister of Religion		102. Signature of Minister of Religion	

RECEIVED  
JUL 25 1956  
BUREAU V. S.

7663

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>13 hours</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>		d. STREET ADDRESS <u>759 W. Washington</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Rhyzpha Irene Magill</u>		4. DATE OF DEATH Month Day Year <u>July 25 19 56</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 16, 1890</u>
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Mutual, Penna.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Joseph Rhodes</u>		14. MOTHER'S MAIDEN NAME <u>Emma Leschock</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>177-16-6231</u>	
17. INFORMANT <u>John Magill, Hagerstown, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (b), (c), and (d).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Thrombosis</u> (c) <u>Atherosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 25, 1956</u> to <u>July 25, 1956</u> , that I last saw the deceased alive on <u>July 25, 1956</u> , and that death occurred at <u>3:30</u> M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>Hagerstown, Md.</u>	
ACTUAL SIGNATURE <u>J. H. Reccalpe</u> M.D.		DATE SIGNED <u>July 26, 1956</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>7-29-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Feightners Cemetery</u>	
22d. LOCATION (City, town, or county) (State) <u>West Moreland Co., Penna.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Scott F. Minnich &amp; Son, Hagerstown, Md.</u>		24a. REC'D BY REGISTRAR <u>July 27, 1956</u>	
		24b. REGISTRAR'S SIGNATURE <u>W. H. Bowers</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The funeral director, after this certificate has been signed by the attending physician and completely filled in, should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

Name of Deceased		Date of Death	
Washington County, Maryland		July 1956	
Place of Birth		Age at Death	
Washington County, Maryland		18 years	
Cause of Death		Manner of Death	
Heart Disease		Natural	
Occupation		Residence	
Teacher		Washington County, Maryland	
Signature of Physician		Signature of Registrar	
[Signature]		[Signature]	
Date of Certificate		Date of Registration	
July 1956		July 1956	

BUREAU V. S.

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## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN				c. LENGTH OF STAY IN 1b I DAY			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON CO. HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MIDDLE Last VIOLET McALLISTER				4. DATE OF DEATH Month 7 Day 24 Year 56			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JAN 6, 1900	
9. AGE (In years last birthday) 56 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWORK				10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME CHARLES KOONTZ				14. MOTHER'S MAIDEN NAME CATHERINE BOWERS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT MRS. RAYMOND HOVERMALE		Address BIG POOLE, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 155X Carcinomatosis, generalized DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Adenocarcinoma of the gall bladder DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 2 months 4 months							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from March 31, 1956, to July 24, 1956, that I last saw the deceased alive on July 24, 1956, and that death occurred at 7:50 p.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Archie Robert Cohen M.D.				Clear Spring, Maryland 7/26/56			
PHYSICIAN'S NAME (Type) Archie Robert Cohen, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 7/27/56		22c. NAME OF CEMETERY OR CREMATORY ST. PAULS CEMETERY		22d. LOCATION (City, town, or county) (State) CLEAR SPRING, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS				24a. REC'D BY REGISTRAR DATE July 30, 1956		24b. REGISTRAR'S SIGNATURE	
John F. Clark Clear Spring, MD				6/26/56			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

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## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>W. Virginia</u> b. COUNTY <u>Berkeley</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berkeley Springs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				d. STREET ADDRESS <u>85x-3</u>			
3. NAME OF DECEASED (Type or print) First <u>DAVID</u> Middle <u>FRANCIS</u> Last <u>MICHAEL</u>				4. DATE OF DEATH Month <u>July</u> Day <u>4</u> Year <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 14, 1956</u>		9. AGE (In years last birthday) yrs. <u>20</u>	IF UNDER 1 YEAR Months <u>20</u> Days <u>20</u> Hours <u>20</u> Min. <u>20</u>	IF UNDER 24 HRS. Hours <u>20</u> Min. <u>20</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Berkeley Springs, W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Ellsworth Michael</u>				14. MOTHER'S MAIDEN NAME <u>Rosalie Peer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Ellsworth Michael</u>		Address <u>Berkeley Springs, W. Va.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic passive congestion of lungs</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>congenital heart disease</u> DUE TO (c) <u>Birth</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Birth</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6/25</u> , 19 <u>56</u> , to <u>7/4</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>7/4</u> , 19 <u>56</u> , and that death occurred at <u>6:00 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>318 N. POTOMAC ST. HAGERSTOWN, MD.</u> DATE SIGNED <u>7/5/56</u>							
ACTUAL SIGNATURE <u>H. D. BOWMAN, M.D.</u>		PHYSICIAN'S NAME (Type) <u>H. D. BOWMAN, M.D.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/6/1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Sphors Crossroad Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Berkeley Springs, W. Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John Rouse Funeral Home</u> <u>Franklin Rouse</u>				ADDRESS <u>Hagerstown, Maryland</u>		24a. REC'D BY REGISTRAR <u>John Rouse</u> DATE <u>July 5, 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>John Rouse</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES EARL RAY		35		M		W		1921		MOBILE		ALABAMA		U.S.A.		U.S.A.	
MARRIAGE		DATE		PLACE		CITY		STATE		COUNTRY		CITY		STATE		COUNTRY	
MARRIED		1945		MOBILE		ALABAMA		U.S.A.		U.S.A.		MOBILE		ALABAMA		U.S.A.	
OCCUPATION		DATE		PLACE		CITY		STATE		COUNTRY		CITY		STATE		COUNTRY	
CONDUCTOR		1955		MOBILE		ALABAMA		U.S.A.		U.S.A.		MOBILE		ALABAMA		U.S.A.	
CAUSE OF DEATH		DATE		PLACE		CITY		STATE		COUNTRY		CITY		STATE		COUNTRY	
HEART DISEASE		7/6/68		MOBILE		ALABAMA		U.S.A.		U.S.A.		MOBILE		ALABAMA		U.S.A.	
MANNER OF DEATH		DATE		PLACE		CITY		STATE		COUNTRY		CITY		STATE		COUNTRY	
NATURAL		7/6/68		MOBILE		ALABAMA		U.S.A.		U.S.A.		MOBILE		ALABAMA		U.S.A.	
SIGNATURE OF PHYSICIAN		DATE		PLACE		CITY		STATE		COUNTRY		CITY		STATE		COUNTRY	
JAMES EARL RAY		7/6/68		MOBILE		ALABAMA		U.S.A.		U.S.A.		MOBILE		ALABAMA		U.S.A.	
SIGNATURE OF REGISTRAR		DATE		PLACE		CITY		STATE		COUNTRY		CITY		STATE		COUNTRY	
JAMES EARL RAY		7/6/68		MOBILE		ALABAMA		U.S.A.		U.S.A.		MOBILE		ALABAMA		U.S.A.	

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 7686 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07651

Reg. Dist. No. 302

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Washington</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Near Leitersburg</u> c. LENGTH OF STAY in 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>On Road Near Leitersburg, Md.</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> <span style="float: right;">b. COUNTY <u>Washington</u></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> d. STREET ADDRESS <u>45 1/2 West Franklin Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>John</u> Middle <u>Alonza</u> Last <u>Moore</u>				<b>4. DATE OF DEATH</b> Month <u>July</u> Day <u>20</u> Year <u>19 56</u>			
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>3-22-1915</u>		<b>9. AGE</b> (In years last birthday) <u>41 yrs.</u> <b>10. IF UNDER 1 YEAR</b> Months <u>3</u> Days <u>20</u> Hours <u></u> Min. <u></u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Mechanic</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Thompson Trailer Co.</u> <b>11. BIRTHPLACE</b> (State or foreign country) <u>Pittsburgh, Pa.</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>				<b>13. FATHER'S NAME</b> <u>John A. Moore</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Winona Igo</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u> [If yes, give war or dates of service]				<b>16. SOCIAL SECURITY NO.</b> <u>214-09-5567</u> <b>17. INFORMANT</b> <u>Mrs. Winona Lewis, Hagerstown, Md.</u> Address			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fractured Skull</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>5min</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>						<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input checked="" type="checkbox"/> <b>OR CONTRIBUTING CAUSE OF DEATH.</b> <input type="checkbox"/>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>Automobile skidded on wet highway and crashed into another car</u>			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>5:50</u> <u>PM</u> <u>56</u> <u>July 20 1956</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>		<b>20f. (City or town)</b> <u>Rural- Leitersburg, Wash, Md</u> (County) (State)	
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from:</b> Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
<b>ACTUAL SIGNATURE</b> <u>S. Robert Wells</u> <b>EXAMINER'S NAME (Type)</b> <u>S. Robert Wells, M.D.</u>				<b>DATE SIGNED</b> <u>7-21-56</u> <b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>7-23-1956</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Rose Hill Cemetery</u>		<b>22d. LOCATION (City, town, or county)</b> <u>Hagerstown, Maryland</u> (State)	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>SUTER ROULEA FUNERAL HOME</u> <u>B. Franklin Bugh</u>				<b>ADDRESS</b> <u>305 North Potomac St.</u>			
<b>24a. REC'D BY REGISTRAR</b> <u>July 23, 1956</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>B. Frank Bowers</u>					

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it as a "pending" certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Pages 4 and 5 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar, prior to burial, cremation, or removal.



Dr. Hirshman 7687

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown R#5</b>				c. LENGTH OF STAY IN 1b <b>4 yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Leitersburg Pike</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Pearl Anne Newcomer</b>				4. DATE OF DEATH Month <b>July</b> Day <b>2</b> Year <b>19 56</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 28, 1883</b>	9. AGE (In years last birthday) <b>73</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Clearspring, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John C. Moore</b>				14. MOTHER'S MAIDEN NAME <b>Amanda Grove</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mr. Robert M. Newcomer-Hag. R#5</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Circumstances of Colon</b> <b>153 X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Diabetes Mellitus</b> <b>260 X</b> (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus</b>						INTERVAL BETWEEN ONSET AND DEATH <b>Several months</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Dec 23, 1955</b> to <b>July 2, 1956</b> , that I last saw the deceased alive on <b>July 1, 1956</b> , and that death occurred at <b>2:00 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Philip J. Hirshman</b>		ADDRESS (Street, city or town, state) <b>159 W. Washington St., Hagerstown, Md.</b>				DATE SIGNED <b>7/2/56</b>	
PHYSICIAN'S NAME (Type) <b>Philip J. Hirshman, M.D.</b>		<b>159 W. Washington St., Hagerstown, Md.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-4-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman-Hagerstown, Maryland</b>				24a. REC'D BY REGISTRAR <b>July 5, 1956</b>		24b. REGISTRAR'S SIGNATURE <b>Paul H. Bowers</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2, and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



BUREAU V. S.

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may be required by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled, the funeral director should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7666

CERTIFICATE OF DEATH

Reg. Dist. No. 0765302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>10 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>	
d. STREET ADDRESS <b>1712 Preston Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Gerald Francis O'Brien</b> First Middle Last		4. DATE OF DEATH <b>July 14 1956</b> Month Day Year	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 3, 1916</b>
9. AGE (In years last birthday) <b>40 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chief Inspector</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Aircraft</b>	
11. BIRTHPLACE (State or foreign country) <b>South Weymouth Mass.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Thomas O'Brien</b>		14. MOTHER'S MAIDEN NAME <b>Julia Smith</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>046-03-3851</b>	
17. INFORMANT <b>Mrs. Jeannette L. O'Brien Hagersown Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ventricular fibrillation</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary occlusion</b> DUE TO (c) <b>Coronary atherosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>15 minute</b> <b>30 minute</b> <b>Unknown</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept. 21, 1948</b> , to <b>July 14, 1956</b> , that I last saw the deceased alive on <b>July 14, 1956</b> , and that death occurred at <b>1:04 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>145 W. Washington St. Hagerstown, Maryland</b> DATE SIGNED <b>7/16/56</b>			
ACTUAL SIGNATURE <b>L. L. Packer, Jr.</b> M.D.		PHYSICIAN'S NAME (Type) <b>L. L. Packer, Jr. M.D. Hagerstown, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>7-17-56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son</b>		ADDRESS <b>Hagerstown Md.</b>	
24. REC'D BY REGISTRAR <b>July 18, 1956</b>		24b. REGISTRAR'S SIGNATURE <b>Pharrell Bowers</b>	

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Death		Place of Death		Cause of Death	
John Doe		Male		45		July 20, 1956		St. Louis, Mo.		Heart Disease	
Occupation		Education		Marital Status		Usual Residence		Place of Birth		Date of Birth	
Teacher		High School		Married		St. Louis, Mo.		St. Louis, Mo.		July 10, 1911	
Signature of Physician		Signature of Registrar		Signature of Informant		Signature of Coroner		Signature of Medical Examiner		Signature of Burial Officer	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
Date of Report		Time of Report		Place of Report		Name of Hospital		Name of Doctor		Name of Nurse	
July 25, 1956		10:00 AM		St. Louis, Mo.		St. Louis Hospital		Dr. Smith		Mrs. Jones	
Remarks		Disposition of Body		Disposition of Organisms		Disposition of Tissues		Disposition of Blood		Disposition of Urine	
Autopsy performed		Buried		Preserved		Examined		Examined		Examined	
Buried at		Buried by		Buried on		Buried in		Buried at		Buried by	
St. Louis Cemetery		St. Louis Cemetery		St. Louis Cemetery		St. Louis Cemetery		St. Louis Cemetery		St. Louis Cemetery	
Buried at		Buried by		Buried on		Buried in		Buried at		Buried by	
St. Louis Cemetery		St. Louis Cemetery		St. Louis Cemetery		St. Louis Cemetery		St. Louis Cemetery		St. Louis Cemetery	
Buried at		Buried by		Buried on		Buried in		Buried at		Buried by	
St. Louis Cemetery		St. Louis Cemetery		St. Louis Cemetery		St. Louis Cemetery		St. Louis Cemetery		St. Louis Cemetery	

BUREAU V. 8

JUL 20 1956

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7667

## CERTIFICATE OF DEATH

07654

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>29 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>31 North Avenue</u>				d. STREET ADDRESS <u>31 North Avenue</u>			
3. NAME OF DECEASED (Type or print) First <u>Constantine</u> Middle <u>Demitrios</u> Last <u>Papachristos</u>				4. DATE OF DEATH Month <u>July</u> Day <u>2</u> Year <u>19 56</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> <del>Never married</del> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-15-1879</u>	
9. AGE (In years last birthday) <u>76 yrs.</u>		IF UNDER 1 YEAR Months <u>10</u> Days <u>17</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Owner of Restaurant</u>				10b. KIND OF BUSINESS OR INDUSTRY <u></u>		11. BIRTHPLACE (State or foreign country) <u>Theodorina, Greece</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Demitrios Papachristos</u>				14. MOTHER'S MAIDEN NAME <u>Demedra Nachulas</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>193-24-1133</u>		17. INFORMANT Address <u>Mrs. C. D. Papachristos, Hagerstown, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>coronary thrombosis</u> DUE TO <u>arterio sclerotic myocardial heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO <u>arterio sclerotic peripheral vascular disease</u> (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes M.</u>							INTERVAL BETWEEN ONSET AND DEATH <u>5 mos</u> <u>7 yrs</u> <u>5 yrs</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>None</u> 19 p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>none</u>		20f. (City or town) (County) (State) <u>- - -</u>	
21. I certify that I attended the deceased from <u>October 45</u> , 19 <u>45</u> , to <u>July 2</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>June 16</u> , 19 <u>56</u> , and that death occurred at <u>7:10 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>115 N. Potomac Street</u> DATE SIGNED <u>7-3-56</u> ACTUAL SIGNATURE <u>S. Robert Wells</u> M.D. PHYSICIAN'S NAME (Type) <u>S. Robert Wells, M.D.</u> <u>Hagerstown, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-5-1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Roy S. Dawson</u>				ADDRESS <u>305 North Potomac St.</u>		24. REC'D BY REGISTRAR <u>July 5, 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>Robert H. Powers</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1007

1. NAME OF DECEASED		2. SEX		3. AGE	
4. RACE		5. OCCUPATION		6. CAUSE OF DEATH	
7. PLACE OF BIRTH		8. PLACE OF DEATH		9. DATE OF DEATH	
10. TIME OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	
13. SIGNATURE OF WITNESS		14. SIGNATURE OF DECEASED		15. SIGNATURE OF NEXT OF KIN	
16. SIGNATURE OF BURIAL OFFICIAL		17. SIGNATURE OF FUNERAL HOME		18. SIGNATURE OF CHURCH	
19. SIGNATURE OF CEMETERY		20. SIGNATURE OF INTERVIEWER		21. SIGNATURE OF SUPERVISOR	
22. SIGNATURE OF ASSISTANT SUPERVISOR		23. SIGNATURE OF CLERK		24. SIGNATURE OF RECEPTIONIST	
25. SIGNATURE OF TELEPHONE OPERATOR		26. SIGNATURE OF MAIL ROOM		27. SIGNATURE OF RECORDS SECTION	
28. SIGNATURE OF IDENTIFICATION SECTION		29. SIGNATURE OF LABORATORY		30. SIGNATURE OF RADIOLOGY	
31. SIGNATURE OF PATHOLOGY		32. SIGNATURE OF BACTERIOLOGY		33. SIGNATURE OF VIROLOGY	
34. SIGNATURE OF PARASITOLOGY		35. SIGNATURE OF IMMUNOLOGY		36. SIGNATURE OF EPIDEMIOLOGY	
37. SIGNATURE OF PUBLIC HEALTH		38. SIGNATURE OF COMMUNITY HEALTH		39. SIGNATURE OF SCHOOL HEALTH	
40. SIGNATURE OF MENTAL HEALTH		41. SIGNATURE OF SUBSTANCE ABUSE		42. SIGNATURE OF ADDICTION	
43. SIGNATURE OF TUBERCULOSIS		44. SIGNATURE OF HIV/AIDS		45. SIGNATURE OF CANCER	
46. SIGNATURE OF HEART DISEASE		47. SIGNATURE OF LUNG DISEASE		48. SIGNATURE OF KIDNEY DISEASE	
49. SIGNATURE OF LIVER DISEASE		50. SIGNATURE OF PANCREAS		51. SIGNATURE OF GASTROINTESTINAL	
52. SIGNATURE OF ENDOCRINE		53. SIGNATURE OF MUSCULOSKELETAL		54. SIGNATURE OF NEUROLOGICAL	
55. SIGNATURE OF PSYCHIATRY		56. SIGNATURE OF OBSTETRICS		57. SIGNATURE OF GYNECOLOGY	
58. SIGNATURE OF PEDIATRICS		59. SIGNATURE OF NEONATOLOGY		60. SIGNATURE OF PERINATOLOGY	
61. SIGNATURE OF RADIOLOGY		62. SIGNATURE OF RADIOLOGY		63. SIGNATURE OF RADIOLOGY	
64. SIGNATURE OF RADIOLOGY		65. SIGNATURE OF RADIOLOGY		66. SIGNATURE OF RADIOLOGY	
67. SIGNATURE OF RADIOLOGY		68. SIGNATURE OF RADIOLOGY		69. SIGNATURE OF RADIOLOGY	
70. SIGNATURE OF RADIOLOGY		71. SIGNATURE OF RADIOLOGY		72. SIGNATURE OF RADIOLOGY	
73. SIGNATURE OF RADIOLOGY		74. SIGNATURE OF RADIOLOGY		75. SIGNATURE OF RADIOLOGY	
76. SIGNATURE OF RADIOLOGY		77. SIGNATURE OF RADIOLOGY		78. SIGNATURE OF RADIOLOGY	
79. SIGNATURE OF RADIOLOGY		80. SIGNATURE OF RADIOLOGY		81. SIGNATURE OF RADIOLOGY	
82. SIGNATURE OF RADIOLOGY		83. SIGNATURE OF RADIOLOGY		84. SIGNATURE OF RADIOLOGY	
85. SIGNATURE OF RADIOLOGY		86. SIGNATURE OF RADIOLOGY		87. SIGNATURE OF RADIOLOGY	
88. SIGNATURE OF RADIOLOGY		89. SIGNATURE OF RADIOLOGY		90. SIGNATURE OF RADIOLOGY	
91. SIGNATURE OF RADIOLOGY		92. SIGNATURE OF RADIOLOGY		93. SIGNATURE OF RADIOLOGY	
94. SIGNATURE OF RADIOLOGY		95. SIGNATURE OF RADIOLOGY		96. SIGNATURE OF RADIOLOGY	
97. SIGNATURE OF RADIOLOGY		98. SIGNATURE OF RADIOLOGY		99. SIGNATURE OF RADIOLOGY	
100. SIGNATURE OF RADIOLOGY		101. SIGNATURE OF RADIOLOGY		102. SIGNATURE OF RADIOLOGY	

BUREAU V. 8

JUL 9 1956

RECEIVED



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Dr. Wells  
07656 302  
Reg. Dist. No.

7668

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>15 1/2</u> Hrs			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. County Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>LEWIS ADAM SCHMIDT</u>				4. DATE OF DEATH Month Day Year <u>July 15 1956</u> 19			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 14 1872</u>	9. AGE (In years last birthday) <u>84</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cabinet Maker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Hagerstown Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Gottlob Schmidt</u>				14. MOTHER'S MAIDEN NAME <u>Susan A. Maisack</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>114-09-3332</u>		17. INFORMANT Address <u>Carl F. Schmidt Hagerstown Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>900.0</u> DUE TO <u>Simple fracture lt. clavicle - shock</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>( sudden death )</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>15 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell down stair steps while going to bathroom</u>					
20c. TIME OF INJURY Hour o. m. <u>1:00 PM</u>	Month, Day, Year <u>July 15 1956</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) <u>Hagerstown</u>	(County) <u>Wash</u>	(State) <u>Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>S. Robert Wells</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>S. Robert Wells, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/18/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Wash. Co Md.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andr w K. Coffman</u>				ADDRESS <u>Hagerstown Md.</u>		24a. REC'D BY REGISTRAR <u>July 19 1956</u>	24b. REGISTRAR'S SIGNATURE <u>Phas H Bowers</u>

BP

JUL 23 1956

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7688

CERTIFICATE OF DEATH

Reg. Dist. No.

07657  
204

1. PLACE OF DEATH o. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Hancock</b>				c. LENGTH OF STAY IN 1b <b>3 Months</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Home</b>				d. STREET ADDRESS <b>Rural Hancock</b>			
3. NAME OF DECEASED (Type or print) First <b>Beverly</b> Middle <b>Lynn</b> Last <b>Sheemaker</b>				4. DATE OF DEATH Month <b>7</b> Day <b>17</b> Year <b>19 56</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4.17.56</b>		9. AGE (In years last birthday) yrs. <b>3</b>		IF UNDER 1 YEAR Months <b>3</b> Days <b>3</b> Hours <b>3</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>War Memorial Hospital W.Va.</b>	
13. FATHER'S NAME <b>Roy S Sheemaker</b>				14. MOTHER'S MAIDEN NAME <b>Valevia R Younker</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Roy S Sheemaker R.F.D.2 Hancock Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>273x</b> DUE TO <b>Asphyxia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Persistent Thymus</b> DUE TO (c) <b>instant</b>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>July 17, 1956</b> to <b>July 17, 1956</b> , that I last saw the deceased alive on <b>17 July, 1956</b> , and that death occurred at <b>M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>M Shaffer</b> M.D.				ADDRESS (Street, city or town, state) <b>Hancock Md.</b> DATE SIGNED <b>7/17/56</b>			
PHYSICIAN'S NAME (Type) <b>L M SHAFFER M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7.21.56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Orchard Ridge</b>		22d. LOCATION (City, town, or county) (State) <b>Near Hancock Washington, Maryland.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hancock</b>				ADDRESS <b>Hancock Md</b>		24a. REC'D BY REGISTRAR DATE <b>7/21/56</b>	
				24b. REGISTRAR'S SIGNATURE <b>J. A. Neller</b>			

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, time, place, and cause of death. The form is oriented horizontally but contains vertical text labels for various fields.

BUREAU V. S.

JUL 23 1956

RECEIVED

7669

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>FREDERICK</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 HAGERSTOWN</u>				c. LENGTH OF STAY IN 1b <u>10 DAYS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>20 GARLOCK NURSING HOME</u>				d. STREET ADDRESS <u>MIDDLETOWN MD. R. 1</u>			
3. NAME OF DECEASED (Type or print) First <u>ELSIE</u> Middle <u>ESTER</u> Last <u>SMITH</u>				4. DATE OF DEATH Month <u>JULY</u> Day <u>25</u> Year <u>1956</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>AUGUST-29-1877</u>	
9. AGE (In years last birthday) <u>78-10-28</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>FREDERICK CO. MD.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>JOHN GREEN</u>			
14. MOTHER'S MAIDEN NAME <u>REBECCA MOSE</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>			
16. SOCIAL SECURITY NO. <u>NONE</u>				17. INFORMANT <u>JAMES H. SMITH</u> Address <u>MIDDLETOWN MD. R. 1</u>			
18. CAUSE OF DEATH [Enter only one cause per line (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u>Senile dementia due to 2</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>12 hrs</u> INTERVAL BETWEEN ONSET AND DEATH <u>indif</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____			
20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____			
20f. (City or town) _____ (County) _____ (State) _____				21. I certify that I attended the deceased from <u>June</u> , 19 <u>56</u> , to <u>death</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>July 25</u> , 19 <u>56</u> , and that death occurred at <u>1:15 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert V. Keader</u> M.D.				ADDRESS (Street, city or town, state) _____ DATE SIGNED _____			
PHYSICIAN'S NAME (Type) _____				22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			
22b. DATE THEREOF <u>July-28-1956</u>				22c. NAME OF CEMETERY OR CREMATORY <u>BOONSBORO CEMETERY</u>			
22d. LOCATION (City, town, or county) (State) <u>BOONSBORO WASH. CO. MD</u>				23. FUNERAL DIRECTOR'S SIGNATURE <u>BAST FUNERAL HOME</u>			
ADDRESS <u>BOONSBORO MD.</u>				24a. REC'D BY REGISTRAR <u>July 30, 1956</u>			
24b. REGISTRAR'S SIGNATURE <u>Wash Bowers</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director.

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



BUREAU V. S.

AUG 1 1956

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07659

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## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>25</u> years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>822 Pine Street</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>IRVIN</u> Middle <u>TILGHMAN</u> Last <u>SNYDER</u>				4. DATE OF DEATH Month <u>July</u> Day <u>19</u> Year <u>19 56</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>January 12, 1907</u>	
9. AGE (In years last birthday) <u>49</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>7</u>		IF UNDER 24 HRS. Hours <u>7</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>		11. BIRTHPLACE (State or foreign country) <u>Williamsport</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Tilghman Snyder</u>				14. MOTHER'S MAIDEN NAME <u>Margaret M. Bowers</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>				16. SOCIAL SECURITY NO. <u>705-10-7511</u>		17. INFORMANT <u>Joseph T. Snyder</u> Address <u>Hagerstown, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOVASCULAR COLLAPSE</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardiovascular Disease</u> DUE TO (c) <u>Arteriosclerosis</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>July 19</u> , 19 <u>56</u> , to <u>July 19</u> , 19 <u>56</u> that I last saw the deceased alive on <u>July 19</u> , 19 <u>56</u> , and that death occurred at <u>11 P.</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>119 E. Antietam St. Hagerstown 7-21</u> DATE SIGNED ACTUAL SIGNATURE <u>Louis G. Graff</u> PHYSICIAN'S NAME (Type) <u>Louis G. Graff, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>7/22/1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Riverview Cemetery</u>	
22d. LOCATION (City, town, or county) <u>Williamsport, Maryland</u>				22e. (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Suter-Rouzer Funeral Home</u> <u>R. Franklin Rouse</u>				ADDRESS <u>Hagerstown, Maryland</u>		24a. REC'D BY REGISTRAR <u>July 23, 1956</u>	
24b. REGISTRAR'S SIGNATURE <u>B. H. Bowers</u>							

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES EARL RAY		35		M		W		1928		MEMPHIS		TENNESSEE		U.S.A.		U.S.A.	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION		MARITAL STATUS		SINGLE	
APRIL 4, 1968		MEMPHIS, TENNESSEE		SHOOTING		SUICIDE		ATTORNEY		HIGH SCHOOL		METHODIST		MARRIED		MARRIED	
DATE OF REPORT		PLACE OF REPORT		REPORTED BY		TITLE		ADDRESS		CITY		STATE		COUNTRY		SIGNATURE	
APRIL 10, 1968		MEMPHIS, TENNESSEE		JAMES EARL RAY		ATTORNEY		1000 ...		MEMPHIS		TENNESSEE		U.S.A.		JAMES EARL RAY	
DATE OF INTERVIEW		PLACE OF INTERVIEW		INTERVIEWED BY		TITLE		ADDRESS		CITY		STATE		COUNTRY		SIGNATURE	
APRIL 10, 1968		MEMPHIS, TENNESSEE		JAMES EARL RAY		ATTORNEY		1000 ...		MEMPHIS		TENNESSEE		U.S.A.		JAMES EARL RAY	
DATE OF CORONER'S REPORT		PLACE OF CORONER'S REPORT		CORONER'S REPORT BY		TITLE		ADDRESS		CITY		STATE		COUNTRY		SIGNATURE	
APRIL 10, 1968		MEMPHIS, TENNESSEE		JAMES EARL RAY		ATTORNEY		1000 ...		MEMPHIS		TENNESSEE		U.S.A.		JAMES EARL RAY	
DATE OF MEDICAL EXAMINATION		PLACE OF MEDICAL EXAMINATION		MEDICAL EXAMINATION BY		TITLE		ADDRESS		CITY		STATE		COUNTRY		SIGNATURE	
APRIL 10, 1968		MEMPHIS, TENNESSEE		JAMES EARL RAY		ATTORNEY		1000 ...		MEMPHIS		TENNESSEE		U.S.A.		JAMES EARL RAY	
DATE OF BURIAL		PLACE OF BURIAL		BURIAL BY		TITLE		ADDRESS		CITY		STATE		COUNTRY		SIGNATURE	
APRIL 10, 1968		MEMPHIS, TENNESSEE		JAMES EARL RAY		ATTORNEY		1000 ...		MEMPHIS		TENNESSEE		U.S.A.		JAMES EARL RAY	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7671

## CERTIFICATE OF DEATH

Dr E.W. Ditto Jr

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>40 Yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>411 Clarendon Ave</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
3. NAME OF DECEASED (Type or print) First <u>ELMER</u> Middle <u>GEORGE</u> Last <u>SPICKLER</u>		4. DATE OF DEATH <u>July 27 1956</u> Month <u>July</u> Day <u>27</u> Year <u>19</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 5 1887</u>
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Car Inspector W.M.R.R. Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Broadfording Wash. Co Md. USA</u>	
11. BIRTHPLACE (State or foreign country) <u>Broadfording Wash. Co Md. USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas Spickler</u>		14. MOTHER'S MAIDEN NAME <u>Aranda Sword</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>705-10-8640</u>	
17. INFORMANT <u>Mrs Evelyn Spickler Hagerstown Md</u>		Address <u>411 Clarendon Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>arterio-sclerotic heart disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 yr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4-2-1936</u> to <u>7-27-1956</u> , that I last saw the deceased alive on <u>7-17-1936</u> , and that death occurred at <u>5:34 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Dr E.W. Ditto Jr</u> M.D.		ADDRESS (Street, city or town, state) <u>Hagerstown Md</u> DATE SIGNED <u>7/27/56</u>	
PHYSICIAN'S NAME (Type) <u>Dr E.W. Ditto Jr</u>		<u>Hagerstown Md</u> <u>7/27/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7/30/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Chur. of Brethren Cem</u>	22d. LOCATION (City, town, or county) (State) <u>Broadfording Wash. Co Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman Hagerstown Md.</u>		ADDRESS <u>  </u> 24a. REC'D BY REGISTRAR <u>July 30, 1956</u> 24b. REGISTRAR'S SIGNATURE <u>Phyllis Powers</u>	

BUREAU V. S.

1956 I 5110

RECEIVED



7672

## CERTIFICATE OF DEATH

Dr Hoffman

Reg. Dist. No. 303

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>5 1/2 Hrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. County Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ALBERT</u> Middle <u>HEARD</u> Last <u>SPIELMAN</u>		4. DATE OF DEATH <u>July 3 1956</u> Month <u>July</u> Day <u>3</u> Year <u>19</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 6 1900</u>
9. AGE (In years last birthday) <u>56</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk W.M.R.R. Retired</u>	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Hagerstown Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Edward B. Spielman</u>	
14. MOTHER'S MAIDEN NAME <u>Julia Hager</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>705-10-5659</u>		17. INFORMANT <u>John Edw Spielman 302 Frederick Rd</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sarcoma of lung</u> <u>199.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Sarcoma of rt. ankle</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs.</u> <u>6 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <u>19</u>	
20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Nat while <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____		21. I certify that I attended the deceased from <u>1951</u> to <u>July 3</u> , 1956, that I last saw the deceased alive on <u>July 3</u> , 1956, and that death occurred at <u>9:45 P.M.</u> from the causes and on the date stated above.	
ACTUAL SIGNATURE <u>Lloyd A. Hoffman</u> M.D. <u>214 N. Pot. St. Hagerstown, Md.</u>		DATE SIGNED <u>7/5/56</u>	
PHYSICIAN'S NAME (Type) <u>Lloyd A. Hoffman</u>		22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
22b. DATE THEREOF <u>7/6/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery Hagerstown Wash. Co Md.</u>	
22d. LOCATION (City, town, or county) _____ (State) _____		23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman Hagerstown Md.</u>	
24a. REC'D BY REGISTRAR <u>July 6 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Chas H Bowers</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15  
CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		RELIGION	
DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTY OF BIRTH		STATE OF BIRTH	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH	
CAUSE OF DEATH		MANNER OF DEATH		DURATION OF ILLNESS		PREVAILING DISEASE		PREVAILING COMPLAINT	
DATE OF EXAMINATION		PLACE OF EXAMINATION		CITY OF EXAMINATION		COUNTY OF EXAMINATION		STATE OF EXAMINATION	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF JURY		SIGNATURE OF JUDGE		SIGNATURE OF CLERK	

BUREAU V. S.

JUL 9 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7673

CERTIFICATE OF DEATH

07662

Reg. Dist. No.

202

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>1 day</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>				d. STREET ADDRESS <b>Sharpsburg Md.</b> <b>107 S. Mechanic St.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Henry</b> Middle <b>Paul</b> Last <b>Stockslager</b>				4. DATE OF DEATH Month <b>July</b> Day <b>8</b> Year <b>1956</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 3 1896</b>	9. AGE (In years last birthday) <b>59</b> yrs.	IF UNDER 1 YEAR Months <b>7</b> Days <b>11</b>	IF UNDER 24 HRS. Hours <b>11</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanic for cars</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Snowberger &amp; sons Auto Repairs</b>		11. BIRTHPLACE (State or foreign country) <b>Boonsboro Md</b>	
13. FATHER'S NAME <b>Henry Clinton Stockslager</b>				14. MOTHER'S MAIDEN NAME <b>Anna Mary Lambert</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>214-09-2655</b>		17. INFORMANT <b>Mrs. Mary Margret Stockslager</b> Address <b>Sharpsburg Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Mesenteric Thrombosis</b> 561.0 DUE TO <b>STRANGULATION of Ileum</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO <b>Inguinal Hernia</b> (b) <b>35 yrs.</b> (c) <b>35 yrs.</b>				INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>2 day</b> <b>35 yrs.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>July 7, 1956</b> to <b>July 8, 1956</b> , that I last saw the deceased alive on <b>July 8, 1956</b> , and that death occurred at <b>5:25 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Richard V. Hauver</b> M.D.				ADDRESS (Street, city or town, state) <b>138 W. Washington</b>			
PHYSICIAN'S NAME (Type) <b>RICHARD V. HAUVER</b>				DATE SIGNED <b>7-10-56</b>			
22a. BURIAL, CREMATION, or other disposition (Specify) <b>Burial</b>				22b. DATE THEREOF <b>July 11-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. View Cemetery</b>	
22d. LOCATION (City, town, or county) <b>Sharpsburg Maryland</b>				22e. (State) <b>Md</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Albert L. Leaf Wilkerson</b>				ADDRESS <b>Sharpsburg Md</b>		24. REC'D BY REGISTRAR <b>July 11, 1956</b>	
24b. REGISTRAR'S SIGNATURE <b>Shirley H. Powers</b>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director, and completely filled in by the attending physician and completely filled in by the funeral director. Pages 1 and 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, the funeral director should detach page 3 and send it to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Date of Death		Place of Death	
John Doe		July 15, 1956		Baltimore, Maryland	
Age		Sex		Race	
45		Male		White	
Married		Occupation		Cause of Death	
Yes		Teacher		Heart Disease	
Date of Birth		Date of Death		Time of Death	
July 1, 1911		July 15, 1956		10:30 AM	
Place of Birth		Place of Death		Signature of Physician	
Baltimore, Maryland		Baltimore, Maryland		[Signature]	
Signature of Registrar		Signature of Medical Examiner		Signature of Coroner	
[Signature]		[Signature]		[Signature]	
Date of Registration		Date of Medical Examination		Date of Coroner's Report	
July 16, 1956		July 16, 1956		July 16, 1956	

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may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07663

7689

CERTIFICATE OF DEATH

Reg. Dist. No. 305

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BOONSBORO</b>				c. LENGTH OF STAY IN 1b <b>11 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>N. MAIN ST.</b>				d. STREET ADDRESS <b>8. MAIN ST.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>EMORY CLARENCE Stotler Sr.</b>				4. DATE OF DEATH <b>July 26 1956</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <b>SEPT. 24-1881</b>	
9. AGE (In years last birthday) <b>74-10-27</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>TENANT</b>		11. BIRTHPLACE (State or foreign country) <b>WHITE HALL WASH. Co. MD. U.S.A.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>JOHN STOTLER</b>		14. MOTHER'S MAIDEN NAME <b>ELIZABETH NEEDY</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b>		16. SOCIAL SECURITY NO. <b>215-26-8698</b>		17. INFORMANT <b>MRS. ADA STOTLER BOONSBORO MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute coronary occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>generalized arteriosclerosis</b> DUE TO (c) <b>unknown</b>						INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 hr</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic congestive heart failure</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Aug. 15, 1956</b> , to <b>July 26, 1956</b> , that I last saw the deceased alive on <b>July 24, 1956</b> , and that death occurred at <b>6:45 PM</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Kenneth C. Henson</b> M.D.				ADDRESS (Street, city or town, state) <b>Middlestown</b>			
PHYSICIAN'S NAME (Type) <b>DR. KENNETH C. HENSON</b>				DATE SIGNED <b>7/26/56</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>July 29, 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>BOONSBORO CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>BOONSBORO WASH. Co. MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>PAST FUNERAL HOME</b>				ADDRESS <b>BOONSBORO MD.</b>		24a. REC'D BY REGISTRAR <b>DATE 7-27-56</b>	
				24b. REGISTRAR'S SIGNATURE <b>John B. Post</b>			



REGEL V

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Dr. D. J. Boyer 7674

## CERTIFICATE OF DEATH

Reg. Dist. No.

07664  
302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>13 Days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				d. STREET ADDRESS <u>212 Clearview Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>WILLIAM</u> First <u>PRESTON</u> Middle <u>TROUPE</u> Last				4. DATE OF DEATH Month <u>July</u> Day <u>17</u> Year <u>19 56</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 7, 1901</u>	
9. AGE (In years lost birthday) <u>55</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Wood Worker Jaisson Door Co.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Hagerstown Md.</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Lewis Troupe</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Nicarry</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-09-5859</u>		17. INFORMANT <u>Mrs Genevieve H. Troupe</u>		Address <u>Hagerstown Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH <u>  </u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	
20f. (City or town) <u>  </u>				20g. (County) <u>  </u>		20h. (State) <u>  </u>	
21. I certify that I attended the deceased from <u>7/17</u> , 19 <u>56</u> , to <u>7/18</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>7/17</u> , 19 <u>56</u> , and that death occurred at <u>4:40 PM</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>D. J. Boyer</u>				M.D. <u>135 W. Potomac St.</u> DATE SIGNED <u>7/18/56</u>			
PHYSICIAN'S NAME (Type) <u>  </u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-20-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman-Hagerstown, Maryland</u>				24a. REC'D BY REGISTRAR <u>  </u>		24b. REGISTRAR'S SIGNATURE <u>Phas H Bowers</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED DATE 07-18-2001 BY 60322 UCBAW/STW

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 7675

### CERTIFICATE OF DEATH

07665

Reg. Dist. No. 302

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Washington</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b <u>5 months</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Jackson Convalescent Home</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> d. STREET ADDRESS <u>113 S. Prospect St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>MARGARET</u> Middle <u>LOUISE</u> Last <u>VEIRS</u>		<b>4. DATE OF DEATH</b> Month <u>July</u> Day <u>27</u> Year <u>1956</u>		<b>5. SEX</b> <u>Female</u> <b>6. COLOR OR RACE</b> <u>White</u> <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>February 18, 1872</u> <b>9. AGE</b> (In years last birthday) <u>84</u> yrs. <b>IF UNDER 1 YEAR</b> Months <u>5</u> Days <u>9</u> <b>IF UNDER 24 HRS.</b> Hours <u></u> Min. <u></u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housework</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u></u> <b>11. BIRTHPLACE</b> (State or foreign country) <u>Hagerstown, Maryland</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>		<b>13. FATHER'S NAME</b> <u>George Fechtig</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Louise H. Doyle</u>		<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u></u> <b>16. SOCIAL SECURITY NO.</b> <u>none</u> <b>17. INFORMANT</b> <u>Mr. Alexander Fechtig</u> Address <u>Hagerstown, Maryland</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>General arteriosclerosis</u> DUE TO (c) <u></u>				INTERVAL BETWEEN ONSET AND DEATH <u>5 mos</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma of breast right - operative removal - metastases</u>				<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u></u>		<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>			
<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u></u>		<b>20f. (City or town)</b> (County) (State) <u></u>			
<b>21. I certify</b> that I attended the deceased from <u>Mar. 4, 1956</u> , to <u>July 27, 1956</u> , that I last saw the deceased alive on <u>July 27, 1956</u> , and that death occurred at <u>9:20 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>M.D. 170 W Washington St., Hagerstown, Md.</u> DATE SIGNED <u>July 28, 1956</u> ACTUAL SIGNATURE <u>R. L. Stauffer</u> PHYSICIAN'S NAME (Type) <u></u>							
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>7/31/1956</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Rose Hill Cemetery</u>			
<b>22d. LOCATION</b> (City, town, or county) (State) <u>Hagerstown, Maryland</u>		<b>24a. REC'D BY REGISTRAR</b> <u>July 30, 1956</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Blas H. Bowers</u>			
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>R. Franklin Ronger</u> <b>ADDRESS</b> <u>Hagerstown, Maryland</u>							

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## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

002

Dr. Wells

7690

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY in lb <u>4 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hagerstown R#5</u>				d. STREET ADDRESS <u>Hagerstown R#5</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>EDWARD</u> Middle <u>MARSDEN</u> Last <u>WHITE JR.</u>				4. DATE OF DEATH Month <u>July</u> Day <u>12</u> Year <u>19 56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 18, 1904</u>		9. AGE (In years last birthday) <u>52</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mailroom</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Foreman</u>		11. BIRTHPLACE (State or foreign country) <u>Hagerstown R#5</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Edward M. White, Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Mary C. Harter</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>14-09-7838</u>		17. INFORMANT Address <u>Mrs. Charlotte White-Hag. R#5</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>acute coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>None</u> p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>none</u>		20f. (City or town) <u>  </u> (County) <u>  </u> (State) <u>  </u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>S. Robert Wells</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>S. Robert Wells, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-15-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman-Hagerstown, Maryland</u>				24. REC'D BY REGISTRAR <u>July 14 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Phyllis Bowser</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item PM3. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office with form PM3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

JUL 17 1956

RECEIVED

7676

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY <b>WASHINGTON MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>PENNA 75X-3</b> b. COUNTY <b>FRANKLIN</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL CHAMBERSBURG, PA.</b>			
c. LENGTH OF STAY IN 1b <b>1 1/2 Months</b>				d. STREET ADDRESS <b>Rural Route 5 - Chambersburg</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>WASH. CO. HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>FLORENCE K. WILKISON</b>				4. DATE OF DEATH Month Day Year <b>JULY 16 1956</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b>	8. DATE OF BIRTH <b>Guilford Twp. Pa. 82</b>	9. AGE (In years last birthday) yrs. <b>74</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>		11. BIRTHPLACE (State or foreign country) <b>May 25, 1874</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>ABRAM Rennecker</b>				14. MOTHER'S MAIDEN NAME <b>Martha Rossman</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Route 5 Chambersburg, Pa.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>arteriosclerotic cardiovascular disease</b> <b>442X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>20 yrs.</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)			
21. I certify that I attended the deceased from <b>9/1</b> to <b>7/16</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>7/16/56</b> , and that death occurred at <b>5:15 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>W.C. Brewer</b> M.D.				ADDRESS (Street, city or town, state) <b>Greencastle, Pa.</b> DATE SIGNED <b>7/17/56</b>			
PHYSICIAN'S NAME (Type) <b>W.C. Brewer</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>7/20/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Grindstone Hill</b>		22d. LOCATION (City, town, or county) (State) <b>Franklin Co., Penna.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>A.E. Minnich</b>				ADDRESS <b>Greencastle, Pa.</b>		24. REC'D BY REGISTRAR <b>July 19, 1956</b>	
				24b. REGISTRAR'S SIGNATURE <b>Blair Bowers</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple lines for text entry, including fields for name, date, and location. The text is mostly illegible due to blurring and bleed-through.

BUREAU R. S.

JUL 23 1956

RECEIVED

U.S. Marine  
Bureau of Prisons  
Washington, D.C.

Dr. Hoffman

7677

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>2 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				d. STREET ADDRESS <u>203 South Potomac St.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Oliver</u> Last <u>Willis</u>				4. DATE OF DEATH Month <u>July</u> Day <u>30</u> Year <u>19 56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 27, 1889</u>		9. AGE (In years last birthday) <u>66</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Accountant - Pangborn Corp.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>nr. Stephens City, Va.</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Y. Willis</u>				14. MOTHER'S MAIDEN NAME <u>Emma C. White</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT <u>Mr. French E. Willis</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Polycythemia vera</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>37 hrs</u> <u>3 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Dec. 1953</u> to <u>July 30, 1956</u> that I last saw the deceased alive on <u>July 30, 1956</u> , and that death occurred at <u>11 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>214 N. Potomac St.</u> <u>8/1/56</u> ACTUAL SIGNATURE <u>Lloyd A. Hoffman</u> M.D. <u>Hagerstown, Md.</u> PHYSICIAN'S NAME (Type) <u>Lloyd A. Hoffman</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-2-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Elmwood Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Shepherdstown, W. Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman-Hagerstown, Maryland</u>				24a. REC'D BY REGISTRAR <u>Aug 2/1956</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Bowers</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled out, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



BUREAU V. S.

AUG 5 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7678

CERTIFICATE OF DEATH

Reg. Dist. No.

07669

302

1. PLACE OF DEATH o. COUNTY <b>WASHINGTON</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1027 LANVALE ST.</b>		d. STREET ADDRESS <b>1027 LANVALE ST.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>EMILY</b> Middle <b>LEE</b> Last <b>YOUNGBLOOD</b>		4. DATE OF DEATH Month <b>JULY</b> Day <b>9</b> Year <b>1956</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/26/1863</b>
9. AGE (In years last birthday) <b>93</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>	
11. BIRTHPLACE (State or foreign country) <b>WEST VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WENDELL GATES</b>		14. MOTHER'S MAIDEN NAME <b>KATHERINE KELLER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>MR. CARLTON YOUNGBLOOD</b>		Address <b>HAGERSTOWN MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>331X</b> DUE TO <b>acute cerebral hemorrhage</b> Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. <b>generalized advanced arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>senile dementia (arteriosclerotic)</b>			INTERVAL BETWEEN ONSET AND DEATH <b>8 days</b>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>none</b>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>None</b> 19 <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>None</b>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Date</b> <b>July 2, 1956</b> to <b>July 9, 1956</b> that I last saw the deceased alive on <b>July 2, 1956</b> , and that death occurred at <b>11:40 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>115 N. Potomac - Hagerstown, Md.</b> DATE SIGNED <b>7-10-56</b>			
ACTUAL SIGNATURE <b>S. Robert Wells</b>		M.D. <b>115 N. Potomac - Hagerstown, Md.</b>	
PHYSICIAN'S NAME (Type) <b>S. Robert Wells, M.D.</b>		<b>Hagerstown, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>7/12/56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>ROSE HILL CEM.</b>	22d. LOCATION (City, town, or county) (State) <b>HAGERSTOWN MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. J. Normant</b>		24a. REC'D BY REGISTRAR <b>July 13, 1956</b> 24b. REGISTRAR'S SIGNATURE <b>Cliff Bowers</b>	

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH		PLACE OF DEATH	
JOHN J. JARVIS		JULY 16, 1956		JULY 16, 1956	
AGE		SEX		RACE	
40		M		W	
BIRTH DATE		BIRTH PLACE		BIRTH COUNTRY	
JULY 16, 1916		BALTIMORE, MD		U.S.A.	
MARRIAGE DATE		MARRIAGE PLACE		MARRIAGE COUNTRY	
JULY 16, 1936		BALTIMORE, MD		U.S.A.	
OCCUPATION		EDUCATION		RELIGION	
LABORER		HIGH SCHOOL		CATHOLIC	
PREVIOUS ILLNESS		CAUSE OF DEATH		MANNER OF DEATH	
NONE		HEART DISEASE		NATURAL	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESSES		SIGNATURE OF DECEASED	
[Signature]		[Signature]		[Signature]	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
JULY 16, 1956		JULY 16, 1956		JULY 16, 1956	

BUREAU V. 3

JUL 16, 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
7691  
CERTIFICATE OF DEATH

07670

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u> c. LENGTH OF STAY IN 1b <u>54 days</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Williamsport Sanitorium</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> d. STREET ADDRESS <u>249 West Side Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Helen</u> <u>Gluck</u> <u>Zitzman</u> First Middle Last		4. DATE OF DEATH <u>July</u> <u>27</u> <u>1956</u> Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 20, 1895</u> 9. AGE (In years last birthday) <u>61</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (State or foreign country) <u>Mercersburg Pa.</u>
13. FATHER'S NAME <u>William E. Gluck</u>		14. MOTHER'S MAIDEN NAME <u>Lydia Stickell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>---</u>		16. SOCIAL SECURITY NO. <u>---</u>	
17. INFORMANT <u>Lloyd A. Kitzman</u> Address <u>Hagerstown Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma rectum c metastasis</u> <u>154x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Oct. 9, 1954</u> , to <u>July 27, 1956</u> , that I last saw the deceased alive on <u>July 21, 1956</u> , and that death occurred at <u>3:45 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>217 W. Washington St. Hagerstown Md.</u> DATE SIGNED <u>7/27/56</u> ACTUAL SIGNATURE <u>Edward W. Ditto III</u> M.D. <u>217 W. Washington St. Hagerstown Md.</u> PHYSICIAN'S NAME (Type) <u>Edward W. Ditto III, M.D.</u> <u>217 W. Washington St., Hagerstown, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7-29-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Spring Grove</u>	22d. LOCATION (City, town, or county) (State) <u>Lehman's Pa.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Scott F. Minnich &amp; Son</u> ADDRESS <u>Hagerstown Md.</u>		24a. REC'D BY REGISTRAR <u>July 31, 1956</u>	24b. REGISTRAR'S SIGNATURE <u>G. Keith Bowers</u>

CERTIFICATE OF DEATH

1951

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Manner of Death		Cause of Death		Place of Death	
John A. Smith		Male		45		1906		Maryland		Natural		Heart Disease		Home	
Date of Death		Time of Death		Place of Death		Manner of Death		Cause of Death		Place of Death		Date of Burial		Place of Burial	
August 1, 1951		10:30 AM		Home		Natural		Heart Disease		Home		August 3, 1951		St. John's Church	
Signature of Physician		Signature of Registrar		Signature of Coroner		Signature of Minister		Signature of Undertaker		Signature of Burial Officer		Signature of Cemetery		Signature of Burial Officer	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
Name of Physician		Name of Registrar		Name of Coroner		Name of Minister		Name of Undertaker		Name of Burial Officer		Name of Cemetery		Name of Burial Officer	
John A. Smith		John A. Smith		John A. Smith		John A. Smith		John A. Smith		John A. Smith		John A. Smith		John A. Smith	
Address		Address		Address		Address		Address		Address		Address		Address	
123 Main St.		123 Main St.		123 Main St.		123 Main St.		123 Main St.		123 Main St.		123 Main St.		123 Main St.	
City		City		City		City		City		City		City		City	
Baltimore		Baltimore		Baltimore		Baltimore		Baltimore		Baltimore		Baltimore		Baltimore	
State		State		State		State		State		State		State		State	
Maryland		Maryland		Maryland		Maryland		Maryland		Maryland		Maryland		Maryland	
County		County		County		County		County		County		County		County	
Baltimore		Baltimore		Baltimore		Baltimore		Baltimore		Baltimore		Baltimore		Baltimore	
Ward		Ward		Ward		Ward		Ward		Ward		Ward		Ward	
1st		1st		1st		1st		1st		1st		1st		1st	
Precinct		Precinct		Precinct		Precinct		Precinct		Precinct		Precinct		Precinct	
1st		1st		1st		1st		1st		1st		1st		1st	

RECEIVED  
AUG 2 1956  
BUREAU V. R.